

1. Within 24 hours after death, this certificate must be filed with the registrar within 72 hours after death. After this time, the third copy of this certificate should be detached for use as a burial transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5140

CERTIFICATE OF DEATH

05146

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN CUMBERLAND		LENGTH OF STAY (in this place) 18 DAYS		CITY (If outside corporate limits, write RURAL end give nearest town) TOWN CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS (If rural give location) 714 LAFAYETTE AVENUE			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH		5. AGE last birthday	
(First) IRA		(Middle) R		(Last) ALBRIGHT		JUNE 20 1955	
6. SEX MALE	7. COLOR OR RACE WHITE	8. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	9. DATE OF BIRTH JUNE 21 1896	10. AGE last birthday 58 yrs.	11. IF UNDER 1 YEAR Months Days	12. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA Meyersdale		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALBRIGHT, LEOPOLD				14. MOTHER'S MAIDEN NAME DEAL, SUSANA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or, or unk.) UNK.		16. SOCIAL SECURITY NO. 191-10-5045		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.				18. MEDICAL CERTIFICATION			
430.0 IMMEDIATE CAUSE (A)				Embolic to Lung, Stomach, Extremities			
ANTECEDENT CAUSE(S) DUE TO				Acute Bacterial Endocarditis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				Hydropneumothorax - Right Lung			
				Acute Cholecystitis			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 3, 1955, to June 20, 1955, that I last saw the deceased alive on June 20, 1955, and that death occurred at 10:31 P.M. from the causes and on the date stated above.							
SIGNATURE J. C. Burton, M.D.				ADDRESS (Street, city, town, state) 133 Virginia Ave, Cumberland, Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6-23-55		NAME OF CEMETERY OR CREMATORY I.O.O.F. Cem.		LOCATION (City, town, or county) (State) Berlin, Pa. Summerset co	
24. REC'D BY REGISTRAR June 23, 1955		REGISTRAR'S SIGNATURE Walter L. Frantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the third copy of this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CLAYTON

22

LATE 1924 - LATE 1925

BUREAU V. 3

JUN 24 1955

1950

1 Outside of City limits

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. This certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5141

CERTIFICATE OF DEATH

05147

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>R. D. # 6 Cumberland,</u>				TOWN <u>R. D. # 6 Cumberland,</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bowling Green</u>				STREET ADDRESS (If rural give location) <u>Bowling Green</u>		I	
3. NAME OF DECEASED (First) (Middle) (Last) <u>RAYMOND</u> <u>LEE</u> <u>BAUGHMAN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June</u> <u>15,</u> <u>19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 15, 1915</u>		9. AGE last birthday <u>39</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Kelly Tire Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Westernport, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13. FATHER'S NAME <u>Quincy Baughman</u>				14. MOTHER'S MAIDEN NAME <u>Edith M. Haskell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes,</u>		16. SOCIAL SECURITY NO. <u>216-09-7084</u>		17. INFORMANT & ADDRESS <u>Mrs. Emily Baughman R. D. # 6 Cumb. Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
154X IMMEDIATE CAUSE (A) <u>Carcinomatosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of Liver</u>						<u>1954</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Carcinoma of Rectum</u>						<u>1947</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>July 1954</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Liver</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) <u>July</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>June 15, 1955</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>June 15, 1955</u>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>54</u> , to <u>June 15</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>June 15</u> , 19 <u>55</u> , and that death occurred at <u>June 15</u> , 19 <u>55</u> , from the causes and on the date stated above.							
SIGNATURE <u>Clayton L. Smith</u>				DATE SIGNED <u>6/16/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/18/55</u>		NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u>		LOCATION (City, town, or county) (State) <u>Westernport, Maryland</u>	
24. REC'D BY REGISTRAR <u>June 17, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Mantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u> <u>Cumberland, Md.</u>			

FBI CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. DATE

11. TIME

12. PLACE

13. TIME

14. PLACE

15. DATE

16. TIME

17. PLACE

18. TIME

19. PLACE

20. NAME OF DECEASED

21. PLACE OF DEATH

22. DATE OF DEATH

23. TIME OF DEATH

24. PLACE OF DEATH

25. CAUSE OF DEATH

BUREAU V. S.

JUN 20 1955

RECEIVED

26. NAME OF DECEASED

27. PLACE OF DEATH

28. DATE OF DEATH

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5203

05148

Reg. Dist. 6

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 6

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Alleghany</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Alleghany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
TOWN <u>Mc Coole</u>		<u>7 yrs</u>		TOWN <u>Mc Coole</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
				<u>1</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
(Type or Print)		<u>STELLA LE ROSA Beckman</u>		<u>June 12</u>		<u>19 55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>14 April 1892</u>	<u>63</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY:	
<u>Housewife</u>		<u>Own Home</u>		<u>Baltimore, Md</u>		<u>U. S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Jacob Bauer</u>				<u>Julia Lower</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>4 No</u>		<u>None</u>		<u>Leo Beckman, Mc Coole, Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
422.2 Immediate cause (a) <u>Cardiac Insufficiency</u>						<u>4 Hrs.</u>	
DUE TO Antecedent cause(s) (b) <u>Chronic Myocarditis</u>						<u>3 yrs.</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>J. V. R. Dunning M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>June 12, 1955</u>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6-15-1955</u>		<u>Philos Cemetery</u>		<u>Westport, Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>6-18-55</u>		<u>Mrs. Joan C. Kelly</u>		<u>C. S. Beal</u>		<u>Westport, Md.</u>	

BUREAU V. S.

JUN 16 1955

RECEIVED

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

05149.

Reg. Dist. No. 7

5142

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>89yrs</u>		TOWN <u>Cumberland, Maryland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>201 Springdale St.</u>				STREET ADDRESS (If rural give location) <u>201 Springdale St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Louis</u> (Middle) <u>Beeche</u> (Last)				(Month) <u>June</u> (Day) <u>29</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 12, 1866</u>	9. AGE last birthday <u>89</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>City St. Dept.</u>	11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Joseph Beeche</u>				14. MOTHER'S MAIDEN NAME <u>Mary Glantzner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Pearl Beeche 201 Springdale St.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> White et work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/12/55</u> , 19 <u>55</u> , to <u>6/29/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6/29/55</u> , 19 <u>55</u> , and that death occurred at <u>5:00P</u> M., from the causes and on the date stated above.							
SIGNATURE <u>W. B. Williams</u> M.D.				ADDRESS (Street, city, town, state) <u>Cumberland</u>		DATE SIGNED <u>7/1/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-2-55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Luke Cem</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR <u>July 2, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u> ADDRESS <u>Cumberland, Md.</u>			

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5193

05150
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 9

1. PLACE OF DEATH: COUNTY <u>Allegany</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Frostburg</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dead on arrival at the Miners Hospital.</u>			2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>Allegany</u> P. Geo CITY (If outside corporate limits write RURAL and give nearest town) <u>Forestville, Md.</u> TOWN STREET ADDRESS (If rural, give location) <u>16X-2</u>		
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>Fred J. Bell</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 18 19 55</u>			
5. SEX: <u>male</u> 6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>March 30-1931</u> 9. AGE last birthday: <u>25</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, if retired): <u>Air Force, Andrews Field, Washington, D.C.</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Meyersdale, Pa.</u>		11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u>	
12. FATHER'S NAME: <u>Harry W. Miller</u>			14. MOTHER'S MAIDEN NAME: <u>Sylvia Schaffer</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>Yes-Now in Air Force</u>		16. SOCIAL SECURITY No.: <u>196-22-8581</u>		17. INFORMANT & ADDRESS: (wife) <u>Donna Bell, Forestville, Md.</u>	

18. MEDICAL CERTIFICATION 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>825X</u> Immediate cause (a) <u>Exsanguination due to all structures on right side of neck severed, transverse processes of 2nd, 3rd, & 4th. cervical vertebrae broken off.</u> Antecedent cause(s) (b) <u>also laceration of left upper arm, after head went through windshield of auto, it hit a utility pole.</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause stating underlying cause last (c)				INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, place blown etc., OF INJURY) <u>one mile west of Frostburg</u>		21c. (City or town) (County) (State) <u>Allegany Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>June 18/55 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>wife lost control of car, trying to get spider out of car.</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>H.V. Downing M.D.</u> H.V. Downing M.D. M. D. CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM. DATE SIGNED <u>June 18-1955</u>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>6-22-55</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>	
DATE REC'D BY LOCAL REG. <u>6-20-55</u>		REGISTRAR'S SIGNATURE <u>Mrs. Nancy N. De</u>		24. FUNERAL DIRECTOR <u>Konhaus, H.R. Meyersdale, Pa.</u>	
LOCATION (City, town, or county) (State) <u>Arlington Va.</u>		ADDRESS			

BUREAU V. S.

JUN 24 1965

RECEIVED

CERTIFICATE OF DEATH

05151

Reg. Dist. No. 4

5143

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		STATE MARYLAND		COUNTY ALLEGANY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) CUMBERLAND		LENGTH OF STAY (in this place) 13 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL		STREET ADDRESS (If rural give location) 121 OFFUTT STREET					
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) NELLIE		(Middle) A.		(Last) BOONE			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH FEBRUARY 5, 1905	9. AGE last birthday 50 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
						Months	Days
						Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Rocky Mt. VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES POLAND				14. MOTHER'S MAIDEN NAME DALE Poland Virginia			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
1747							
IMMEDIATE CAUSE (A) Adenocarcinoma of the Uterus				INTERVAL BETWEEN ONSET AND DEATH approx 6 months			
ANTECEDENT CAUSE(S) DUE TO (B) Adenocarcinoma of the Uterus							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Adenocarcinoma of the Uterus							
19. DATE OF OPERATION 6-6-55				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov 19 54, to June 19 55, that I last saw the deceased alive on June 3, 19 55, and that death occurred at 12:25 PM, from the causes and on the date stated above.							
SIGNATURE <i>James F. Scarpelli</i>				ADDRESS (Street, city, town, state) 133 Virginia Ave, Cumberland, Md.		DATE SIGNED 6/3/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6-6-55		NAME OF CEMETERY OR CREMATORY Rock Oak cem		LOCATION (City, town, or county) (State) Rock Oak, W. Va.	
24. REC'D BY REGISTRAR June 6, 1955		REGISTRAR'S SIGNATURE <i>Walter R. Frank, M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		MARYLAND		STATE <u>PENNSYLVANIA</u> COUNTY <u>BEDFORD</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>CUMBERLAND</u>		<u>7 DAYS</u>		TOWN <u>SAND PATCH</u>		<u>75X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		STREET ADDRESS		(If rural give location)	
60				R.F.D. #1		✓	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JOHN</u> (Middle) <u>E. J.</u> (Last) <u>BOOR</u>				(Month) <u>JUNE</u> (Day) <u>7</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>MALE</u>	<u>WHITE</u>	<u>WIDOWED</u>	<u>FEB. 27, 1875</u>	<u>80</u> yrs.	Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Gas Station Op.</u>		<u>Self Employed</u>		<u>BEDFORD VALLEY, PENNA.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>HENRY BOOR</u>				<u>ELMIRA BLAIR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Floyd M. Boor, Dand Patch, Pa Rt 1</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.2 IMMEDIATE CAUSE (A) <u>Chronic Myocardiosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic Prostatitis</u>				2 yrs			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 7, 1955</u> to <u>June 7, 1955</u> , that I last saw the deceased alive on <u>June 7, 1955</u> , and that death occurred at <u>8:35 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>John A. Topper</u> M.D.				ADDRESS (Street, city, town, state) <u>Hennepin Co</u> DATE SIGNED <u>6/7/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 9, 1955</u>		<u>Bethel Cem.</u>		<u>Near Centerville, Pa.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>June 9, 1955</u>		<u>Walter R. Frantz, M.D.</u>		<u>John J. Hafer, Cumberland, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

1. NAME OF DECEASED HENRY L. ROY		2. SEX MALE		3. RACE WHITE		4. AGE 60		5. DATE OF DEATH JULY 1, 1955	
6. PLACE OF DEATH HOME		7. CAUSE OF DEATH HEART DISEASE		8. MANNER OF DEATH NATURAL		9. SIGNATURE OF PHYSICIAN J. H. ROY		10. SIGNATURE OF REGISTRAR J. H. ROY	
11. PLACE OF BIRTH BALTIMORE, MARYLAND		12. DATE OF BIRTH JULY 1, 1895		13. SEX MALE		14. RACE WHITE		15. AGE 60	
16. PLACE OF DEATH HOME		17. CAUSE OF DEATH HEART DISEASE		18. MANNER OF DEATH NATURAL		19. SIGNATURE OF PHYSICIAN J. H. ROY		20. SIGNATURE OF REGISTRAR J. H. ROY	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05153

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CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL or end give nearest town) 02 CUMBERLAND		LENGTH OF STAY (in this place) 24HRS		CITY (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL MEMORIAL AVE.				STREET ADDRESS (If rural give location) 205 S. LEE ST.			
3. NAME OF DECEASED (Type or Print) MR. NOAH Baldwin B. BOOTH				4. DATE OF DEATH (Month) (Day) (Year) JUNE 15 1955			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH 9-24-80	9. AGE last birthday 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mach. Operator		10b. KIND OF BUSINESS OR INDUSTRY Kelly Tire Co.		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Glaiborne S. Booth				14. MOTHER'S MAIDEN NAME ELIZA Dungan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 214-07-0471		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 2 days years			
ANTECEDENT CAUSE(S) DUE TO (B) Hypertension C, V, Disease							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 9, 1955, to June 15, 1955, that I last saw the deceased alive on June 15, 1955, and that death occurred at 4:15 PM, from the causes and on the date stated above.							
SIGNATURE B. M. Schindler				DATE SIGNED 6/16/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 19, 1955		NAME OF CEMETERY OR CREMATORY Lake View Cemetery		LOCATION (City, town, or county) (State) Victoria, Va.	
24. REC'D BY REGISTRAR June 17, 1955		REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.			

CERTIFICATE OF DEATH

Reg. Dist. No.

NAME OF DECEASED

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>3/5/55</u>		TOWN <u>Cumberland</u>		TOWN <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegany County Infirmary</u>				STREET ADDRESS (If rural give location) <u>415 Fayette Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Anna</u> (Middle) <u>Mae</u> (Last) <u>Brenaman</u>				June 2 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>11/5/1883</u>	<u>71</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>own home</u>		<u>W. Piedmont, N. Va.</u>		<u>U. S. A.</u>	
13. FATHER'S NAME <u>Edward G. DeWitt</u>				14. MOTHER'S MAIDEN NAME <u>Ada Florence Ravenscraft</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Allegany County Infirmary Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Intestinal Carcinoma</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Generalized arteriosclerosis</u>						<u>?</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Drainage</u>						<u>8 mos</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar 5 1955</u> to <u>June 2 1955</u> , that I last saw the deceased alive on <u>June 2 1955</u> , and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James E. McLean</u>		M. D.		ADDRESS (Street, city, town, state) <u>49 Greene St.</u>		DATE SIGNED <u>6-3-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6/5/55</u>		<u>Rose Hill Cemetery</u>		<u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>June 5, 1955</u>		<u>Walter R. Frantz, M.D.</u>		<u>Charles L. George</u>		<u>Cumberland, Md.</u>	

CERTIFICATE OF DEATH

Form 100-100

1. Name of deceased (Print name and surname)

2. Date of death

3. Place of death (City, town, or village)

4. Age at death

5. Sex

6. Cause of death (State immediately and briefly)

7. Duration of illness

8. Occupation

9. Name and address of physician

10. Name and address of informant

11. Name and address of funeral home

12. Name and address of next of kin

13. Name and address of hospital

14. Name and address of cemetery

15. Name and address of registrar

16. Name and address of undertaker

17. Name and address of mortician

18. Name and address of funeral home

19. Name and address of cemetery

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Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>02 Cumberland</u>		LENGTH OF STAY (in this place) <u>6 days</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>02 Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>60 Memorial Hospital</u>				STREET ADDRESS (If rural, give location) <u>37 Oak St.</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>Anna</u>		(Middle) <u>G.</u>		(Last) <u>Brinkman</u>		(Month) (Day) (Year) <u>June 15 19 55</u>	
5. SEX: <u>female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH: <u>July 6-1890</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Own home</u>		9. AGE last birthday: <u>64</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>Fredrick County, Va.</u>	
13. FATHER'S NAME: <u>Robert Jolley</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>4 no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Memorial Hospital records.</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH		
<u>334x</u> Immediate cause (a) <u>Chronic arachnoiditis</u> DUE TO Antecedent cause(s) (b) <u>Hydrocephalis</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Cerebral edema</u>			? ? ?		
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Fell-two lacerations of scalp.</u>			6 days.		
19a. DATE OF OPERATION: <u>2</u>			19b. MAJOR FINDING OF OPERATION:		
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office, bldg., etc., INJURY <u>Home</u>)		21c. (City or town) (County) (State) <u>Cumberland Allegany Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>June 9/55 P. M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell down steps at Home.</u>	

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

H. V. Deming M.D.

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED
 DEPUTY MEDICAL EXAMINER ☐
 ASSISTANT MEDICAL EXAM. ☒ June 16-1955

23. BURIAL, CREMATION, REMOVAL (Specify): Removal DATE THEREOF June 18, 1955 NAME OF CEMETERY OR CREMATORY Willcrest Burial Park LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 17, 1955Walter R. Parry, M.D.James F. Scarfelli, ""Scarfelli

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 20 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5194 **CERTIFICATE OF DEATH**

03156

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>22</u>		LENGTH OF STAY (In this place) <u>4-5 yrs.</u>		TOWN <u>Frostburg</u>		TOWN <u>22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>61 Miners Hospital</u>				STREET ADDRESS (If rural give location) <u>Frost Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>LEWIS</u>		(Middle) <u>BEEMAN</u>		(Last) <u>BROWNE</u>		(Month) <u>June</u> (Day) <u>3</u> (Year) <u>19 55</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Aug. 24, 1867</u>	9. AGE last birthday <u>87</u> yrs.	IF UNDER 1 YEAR Months <u>.</u> Days <u>.</u>		IF UNDER 24 HRS. Hours <u>.</u> Min. <u>.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Episcopal church</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lewis B. Browne</u>				14. MOTHER'S MAIDEN NAME <u>Augusta J. Bayles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>9</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Leslie Brode, Frostburg, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						1 day	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovascular disease</u>						years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan.</u> , 19 <u>48</u> , to <u>June 3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>June 3</u> , 19 <u>55</u> , and that death occurred at <u>11:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>John B. Davis</u> M.D.				ADDRESS (Street, city, town, state) <u>Frostburg, Maryland</u>		DATE SIGNED <u>6/4/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-9-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Angel Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Havre de Grace, Md.</u>	
24. REC'D BY REGISTRAR <u>6-10-55</u>		REGISTRAR'S SIGNATURE <u>Mr. Nancy A. Re</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst</u>		ADDRESS <u>Frostburg, Md.</u>	

CERTIFICATE OF DEATH

1955

Book No. 10

1. NAME OF DECEASED

MARYLAND

2. PLACE OF BIRTH

3. DATE OF BIRTH

4. SEX

5. RACE

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. DATE OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF STATE

20. SIGNATURE OF FEDERAL

21. SIGNATURE OF LOCAL

22. SIGNATURE OF COUNTY

23. SIGNATURE OF CITY

24. SIGNATURE OF TOWNSHIP

25. SIGNATURE OF VILLAGE

26. SIGNATURE OF HAMLET

27. SIGNATURE OF CENSUS

28. SIGNATURE OF MARRIAGE

29. SIGNATURE OF BIRTH

BUREAU V. S.

MAY 18 1955

RECEIVED

5148 **CERTIFICATE OF DEATH**Reg. Dist. No. 4

05157

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>12 days</u>		TOWN <u>Cumberland</u>		<u>02</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location) <u>223 So. Mechanic St.</u>			
3. NAME OF DECEASED (Type or Print) <u>Ralph E Burrall</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>6-4-55</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>6-15-96</u>	
9. AGE last birthday <u>58</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months Days		Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Employee</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Theatre</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Burrall</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Farrell Burrall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes War I</u>				16. SOCIAL SECURITY NO. <u>214-05-7617</u>		17. INFORMANT & ADDRESS <u>Hospital Chart</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
163X IMMEDIATE CAUSE (A) <u>Carcinomatosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma Rplung.</u>				<u>1 yr.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>6-4-55</u>		19b. MAJOR FINDINGS OF OPERATION <u>excised</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-23-55</u> , 19 <u>55</u> , to <u>6-4-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6-4-55</u> , 19 <u>55</u> , and that death occurred at <u>10:30 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>6-6-55</u>			
M.D. <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Cumberland Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/7/55</u>		NAME OF CEMETERY OR CREMATORY <u>Zion Memorial Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR <u>June 7, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frank, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc.</u>		ADDRESS <u>Cumberland, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS-A15C 1-55 10M

BUREAU V. S.

JUN 8 1955

RECEIVED

5149

05158

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town)
 TOWN Cumberland LENGTH OF STAY (in this place) 20 days
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany
 CITY (If outside corporate limits write RURAL and give nearest town)
 OR TOWN Cumberland
 STREET ADDRESS (If rural, give location) 1100 Virginia Ave.

3. NAME OF DECEASED: (First) (Middle) (Last)
 (Type or Print) Anna C. Cage

4. DATE OF DEATH (Month) (Day) (Year)
June 24 19 55

5. SEX: 6. COLOR OR RACE: 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) 8. DATE OF BIRTH: 9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.
Female white widow Jan. 4-1872 83 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Housewife 10b. KIND OF BUSINESS OR INDUSTRY: Own home 11. BIRTHPLACE (State or foreign country): Little Orleans, Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

Harmon Brinkman

14. MOTHER'S MAIDEN NAME:

Elizabeth (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
no

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS: Memorial Hospital records
(son) Roy F. Dawson, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a) Pulmonary embolism (massive)

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

20 days

Antecedent cause(s)

(b) Collapsed lungs (bilateral)

DUE TO

?

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(c) Rheumatic valvulitisa few years.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Comminuted fracture of right lower radius & Ulna.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20 days.

20. AUTOPSY?

Yes ☐ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Home

21c. (City or town) (County) (State)
Cumberland Allegany Md.

21d. TIME (Month) (Day) (Year) June 5/55 P. M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR? Tried to open refrig- erator door, mis-step, fell to the floor.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

H.V. Deming M.D.H.V. Deming M.D. M.D.

CHIEF MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

ASSISTANT MEDICAL EXAM.

June 24-1955

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)
June 27 1955 Stannmount Cemetery Cumberland, Maryland

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 26, 1955Walter R. Frantz, M.D.William H. Light, " "" "

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 28 1955

RECEIVED

5150

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND, MD.		LENGTH OF STAY (in this place) 1 HR. 11 MIN.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CUMBERLAND		02	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.,				STREET ADDRESS (If rural give location) 407 RIDGEWOOD AVE.,		1	
3. NAME OF DECEASED (First) (Middle) (Last) BOY CALHOUN				4. DATE OF DEATH (Month) (Day) (Year) JUNE 10 19 55			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH JUNE 10, 1955	9. AGE last birthday yrs. 1	IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS. Days 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HOBERT G. CALHOUN				14. MOTHER'S MAIDEN NAME BETTY J. RICHARDSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) 4 No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Robert G. Calhoun, Cumberland Md			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				1 Hour			
7593 IMMEDIATE CAUSE (A) Splenic Pulmonary collapse							
ANTECEDENT CAUSE(S) DUE TO (B) Spongiform Brain							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Multiple Deformities of Head & Ext							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Generalized Edema				758.6			
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) None		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6-10-55 , 19....., to 6-10-55 , 19....., that I last saw the deceased alive on June 10, 1955 , and that death occurred at 9:25 A.M. from the causes and on the date stated above.							
SIGNATURE J. Hallinan, M.D.				DATE SIGNED 6/10/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 11 1955		NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		LOCATION (City, town, or county) (State) Cumberland Md.	
24. REC'D BY REGISTRAR June 11, 1955		REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Wm H. Kight		ADDRESS Cumberland, Md.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

BUREAU V

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5204

CERTIFICATE OF DEATH

05160

Reg. Dist. No. 8

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE MD.		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN Lonaconing		42 yrs.		TOWN Lonaconing		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 East Main Street				East Main Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Margaret (Middle) Mary (Last) Conroy				(Month) June (Day) 28 (Year) 19 55			
5. SEX	6. RACE OR COLOR	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Married	Feb, 22, 1913	42 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Operator of Elec. Appliance Store				Lonaconing, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Patrick McDonough				Margaret Stakem			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
4 No				T.E. Conroy, Lonaconing, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION (Husband)		INTERVAL BETWEEN ONSET AND DEATH	
171X IMMEDIATE CAUSE (A) Carcinoma of Cervix						13 mo.	
ANTECEDENT CAUSE(S) DUE TO (B) Vertebral & Abdominal							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Cerebral Metastases							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
0							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July , 19 52 , to 6/28 , 19 55 , that I last saw the deceased alive on 6/28 , 19 55 , and that death occurred at 10:20 P.M. from the causes and on the date stated above.							
SIGNATURE George Richard				M.D. Lonaconing		DATE SIGNED 7-1-55	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial		July 1st. 1955		St. Marys Cemetery		Lonaconing, MD.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 7-1-55		Jannette M. Pool		George Eichhorn, Lonaconing, MD.			

CERTIFICATE OF DEATH

STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1955

Allegany

MALE

DATE

HANDED IN

Allegany

Interpreting

Interpreting

Interpreting

West Main Street

West Main Street

County

County

County

40

40

40

40

40

Interpreting

Interpreting

Interpreting

Interpreting

Interpreting

Interpreting

Interpreting

BUREAU V. 1

JUL 11 1955

RECEIVED

July 11, 1955, at Allegany, West Virginia

George W. Johnson, Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5205

05161

Reg. Dist. 6

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Mont.</u>	
CITY (If outside corporate limits write RURAL and give nearest town) <u>Dawson</u>		LENGTH OF STAY (in this place) <u>1 1/2 mile south of route 220</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Chevy Chase</u>		<u>15x-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dead on arrival at the Potomac Valley H. Keyser, W. Va.</u>				STREET ADDRESS (If rural, give location) <u>4928 Hampden Lane</u>			
3. NAME OF DECEASED: (First) <u>Earl</u> (Middle) <u>Elwood</u> (Last) <u>Critchfield</u>				4. DATE OF DEATH <u>June 19</u> 19 <u>55</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>		8. DATE OF BIRTH: <u>May 31-1920</u>	
9. AGE last birthday: <u>35</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>laborer Columbia Specialty, Inc.</u>		11. BIRTHPLACE (State or foreign country): <u>Somerset, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Harry R. Critchfield</u>				14. MOTHER'S MAIDEN NAME: <u>Arminta Gohring</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>208-10-0283</u>		17. INFORMANT & ADDRESS: <u>Mrs. Alverda R. Custer, Cresaptown, Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
<u>823x</u> Immediate cause (a) <u>Intracranial hemorrhage</u> DUE TO							
Antecedent cause(s) (b) <u>a crushed skull also puncture wound in right occipital region & laceration of forehead.</u> DUE TO <u>Automobile accident.</u> (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>June 19/55</u>				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, factory, street, office bldg., etc.) <u>Home, factory, route 220</u>		21c. (City or town) <u>(near) Dawson</u>		(County) <u>Allegany</u> (State) <u>Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) <u>June 19/55</u> <u>AM</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Lights went out, ran off road, car rolled over, thrown out.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>H.V. Deming M.D.</u> <i>H.V. Deming M.D.</i>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>June 20-1955</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>June 21-1955</u>		NAMES OF CEMETERY OR CREMATORY <u>Samuels Cemetery</u>		LOCATION (City, town, or county) <u>Somerset, Pa.</u> (State)	
DATE REC'D BY LOCAL REG. <u>6-21-55</u>		REGISTRAR'S SIGNATURE <u>Mrs. Jan C. Kelly</u>		24. FUNERAL DIRECTOR <u>Rogers Funeral Home, Keyser, W. Va.</u> ADDRESS			

BUREAU V. S.

JUN 23 1955

RECEIVED

5151 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>		LENGTH OF STAY (In this place) <u>52 Years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crump Nursing Home</u>				STREET ADDRESS (If rural give location) <u>223 Humbird Street</u>			
3. NAME OF DECEASED (Type or Print) <u>BESSIE</u> (First) <u>MAY</u> (Middle) <u>DARR</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>June 26, 1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 17, 1886</u>		9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Inglesmith, Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Emanuel Smith</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen Cavander</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>4 No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Charles Griffith, Cumberland, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Acute Myocardial Infarction - Acute Congestive Failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardiac Vascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>M.</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 4, 1955, to June 24, 1955, that I last saw the deceased alive on June 24, 1955, and that death occurred at 2:00 P.M. from the causes and on the date stated above.							
SIGNATURE <u>Dr. J. J. Hafer</u>		DATE THEREOF <u>June 29, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cem</u>		LOCATION (City, town, or county) <u>Cumberland, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>June 29, 1955</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u>		DATE SIGNED <u>6/28/55</u>	

VS A15C 1-55 10M

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

1. Within corporate limits.

1
Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

05163

Reg. Dist. No. 4

5152

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		25 DAYS		TOWN CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				137 POLK STREET			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
NELLIE C. DE LUCA				JUNE 15 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE	WHITE	WIDOWED	OCT. 18 1890	64 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Ownhome		#WVA# Cumberland, Md.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
FRANK MOLINARI Sr.				JOSEPHINE SANTELLI			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		Mrs. Lena Belfoure Cumberland, Md			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
2040 IMMEDIATE CAUSE (A)				Lymphatic Leukemia			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7/10/51 to 6/15/55, that I last saw the deceased alive on 6/15/55, and that death occurred at 11:30 A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
J. Williams				Cumberland, Md		6/15/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		6-18-55		St Mary's Cem.		Cumberland, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
June 17, 1955		Walter R. Frantz, M.D.		James F. Scarpelli		Cumberland, Md	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

7153

NAME OF DECEASED JOSEPHINE SANTILLI		AGE 52		SEX FEMALE		RACE WHITE		MARRIAGE WIDOWED		DATE OF DEATH OCT. 11 1955		PLACE OF DEATH HOME	
BIRTH DATE APR. 1903		BIRTH PLACE ITALY		EDUCATION 8 YEARS		OCCUPATION SEWING		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		CERTIFICATE NO. 7153	
FATHER'S NAME JOSEPH SANTILLI		MOTHER'S NAME MARY SANTILLI		DECEASED'S ADDRESS 135 POLK STREET		CITY BALTIMORE		STATE MARYLAND		COUNTY WICOMICO		ZIP CODE 21201	
DECEASED'S SIGNATURE <i>[Signature]</i>		WITNESS SIGNATURE <i>[Signature]</i>		DECEASED'S ADDRESS 135 POLK STREET		CITY BALTIMORE		STATE MARYLAND		COUNTY WICOMICO		ZIP CODE 21201	

RECEIVED
JUN 20 1955
BUREAU V. S.

2102708780

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5153 CERTIFICATE OF DEATH

05164

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY ALLEGANY CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND				2. USUAL RESIDENCE (HOME) OF DECEASED STATE W. VA. COUNTY MINERAL CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 85X-3 RIDGELEY			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL				STREET ADDRESS (If rural give location) RT. #1			
3. NAME OF DECEASED (Type or Print) ISRAEL		(First)		(Middle) E.		(Last) DETRICK SR.	
4. DATE OF DEATH JUNE 6		(Month)		(Day)		(Year) 19 55	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH FEB. 3, 1897		9. AGE last birthday -59- 58 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER-CELANESE Celanese Corp.			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD. Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ISRAEL S. DETRICK				14. MOTHER'S MAIDEN NAME CARRIE JOHNSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No.		16. SOCIAL SECURITY NO. 214-07-3495		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) 416X Uremia						INTERVAL BETWEEN ONSET AND DEATH 1 mo	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Rheumatic Heart Disease						unknown	
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12-7 , 19 53 , to 6-6 , 19 55 , that I last saw the deceased alive on 6-6 , 19 55 , and that death occurred at 3:20 A.M. from the causes and on the date stated above.							
SIGNATURE Raeza W. Baccin				ADDRESS (Street, city, town, state) Cumberland, Md.		DATE SIGNED 6-6-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6/9/55		NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		LOCATION (City, town, or county) (State) Cumberland, Md.	
24. REC'D BY REGISTRAR June 8, 1955		REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Charles L. George ADDRESS Cumberland, Md.			

CERTIFICATE OF DEATH

REG. NO. 100-100

1. NAME OF DECEASED (Print or Type)

JOHN J. JONES

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. PLACE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF FUNERAL HOME

16. SIGNATURE OF BURIAL SOCIETY

17. SIGNATURE OF CEMETERY

18. SIGNATURE OF CHURCH

19. SIGNATURE OF MINISTRY

20. SIGNATURE OF DECEASED

21. SIGNATURE OF FUNERAL HOME

22. SIGNATURE OF BURIAL SOCIETY

23. SIGNATURE OF CEMETERY

24. SIGNATURE OF CHURCH

25. SIGNATURE OF MINISTRY

26. SIGNATURE OF DECEASED

27. SIGNATURE OF FUNERAL HOME

28. SIGNATURE OF BURIAL SOCIETY

29. SIGNATURE OF CEMETERY

30. SIGNATURE OF CHURCH

31. SIGNATURE OF MINISTRY

32. SIGNATURE OF DECEASED

33. SIGNATURE OF FUNERAL HOME

34. SIGNATURE OF BURIAL SOCIETY

35. SIGNATURE OF CEMETERY

36. SIGNATURE OF CHURCH

37. SIGNATURE OF MINISTRY

38. SIGNATURE OF DECEASED

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41. SIGNATURE OF CEMETERY

42. SIGNATURE OF CHURCH

43. SIGNATURE OF MINISTRY

44. SIGNATURE OF DECEASED

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47. SIGNATURE OF CEMETERY

48. SIGNATURE OF CHURCH

49. SIGNATURE OF MINISTRY

50. SIGNATURE OF DECEASED

51. SIGNATURE OF FUNERAL HOME

52. SIGNATURE OF BURIAL SOCIETY

53. SIGNATURE OF CEMETERY

54. SIGNATURE OF CHURCH

55. SIGNATURE OF MINISTRY

56. SIGNATURE OF DECEASED

57. SIGNATURE OF FUNERAL HOME

58. SIGNATURE OF BURIAL SOCIETY

59. SIGNATURE OF CEMETERY

60. SIGNATURE OF CHURCH

61. SIGNATURE OF MINISTRY

62. SIGNATURE OF DECEASED

63. SIGNATURE OF FUNERAL HOME

64. SIGNATURE OF BURIAL SOCIETY

65. SIGNATURE OF CEMETERY

66. SIGNATURE OF CHURCH

67. SIGNATURE OF MINISTRY

68. SIGNATURE OF DECEASED

69. SIGNATURE OF FUNERAL HOME

70. SIGNATURE OF BURIAL SOCIETY

71. SIGNATURE OF CEMETERY

72. SIGNATURE OF CHURCH

73. SIGNATURE OF MINISTRY

74. SIGNATURE OF DECEASED

75. SIGNATURE OF FUNERAL HOME

76. SIGNATURE OF BURIAL SOCIETY

77. SIGNATURE OF CEMETERY

78. SIGNATURE OF CHURCH

79. SIGNATURE OF MINISTRY

80. SIGNATURE OF DECEASED

81. SIGNATURE OF FUNERAL HOME

82. SIGNATURE OF BURIAL SOCIETY

83. SIGNATURE OF CEMETERY

84. SIGNATURE OF CHURCH

85. SIGNATURE OF MINISTRY

86. SIGNATURE OF DECEASED

87. SIGNATURE OF FUNERAL HOME

88. SIGNATURE OF BURIAL SOCIETY

89. SIGNATURE OF CEMETERY

90. SIGNATURE OF CHURCH

91. SIGNATURE OF MINISTRY

92. SIGNATURE OF DECEASED

93. SIGNATURE OF FUNERAL HOME

94. SIGNATURE OF BURIAL SOCIETY

95. SIGNATURE OF CEMETERY

96. SIGNATURE OF CHURCH

97. SIGNATURE OF MINISTRY

98. SIGNATURE OF DECEASED

99. SIGNATURE OF FUNERAL HOME

100. SIGNATURE OF BURIAL SOCIETY

101. SIGNATURE OF CEMETERY

102. SIGNATURE OF CHURCH

103. SIGNATURE OF MINISTRY

104. SIGNATURE OF DECEASED

105. SIGNATURE OF FUNERAL HOME

106. SIGNATURE OF BURIAL SOCIETY

107. SIGNATURE OF CEMETERY

108. SIGNATURE OF CHURCH

109. SIGNATURE OF MINISTRY

110. SIGNATURE OF DECEASED

111. SIGNATURE OF FUNERAL HOME

112. SIGNATURE OF BURIAL SOCIETY

113. SIGNATURE OF CEMETERY

BUREAU V. S.

JUN 9 1955

RECEIVED

ROSE HILL CEMETERY

CHARLES A. GEORGE CEMETERY

RECEIVED

RECEIVED
JUN 10 1955
JUN 11 1955
JUN 12 1955
JUN 13 1955
JUN 14 1955
JUN 15 1955
JUN 16 1955
JUN 17 1955
JUN 18 1955
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JUL 1 1955
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JUL 3 1955
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1. Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05165

5154

CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town) 02 TOWN CUMBERLAND		LENGTH OF STAY (In this place) 13 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) Near CUMBERLAND		RURAL	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL MEMORIAL AVE.				STREET ADDRESS (If rural give location) Route # 6, Bowling Green			
3. NAME OF DECEASED (Type or Print) (First) Darwin (Middle) Ivan D. (Last) DE WITT				4. DATE OF DEATH (Month) (Day) (Year) JUNE 9 55			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH FEB. 19, 1907	9. AGE last birthday 48 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HIRAM DE WITT				14. MOTHER'S MAIDEN NAME VERNIE GROVES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 195-01-2000		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) Acute Left Ventricular failure				INTERVAL BETWEEN ONSET AND DEATH 10 minutes			
ANTECEDENT CAUSE(S) DUE TO WITH Pulmonary Edema							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Acute Recent Myocardial Infarction				10 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 2 old Coronary Thromboses				74 + 44			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 4, 1955, to June 9, 1955, that I last saw the deceased alive on June 9, 1955, and that death occurred at 12:50 PM from the causes and on the date stated above.							
SIGNATURE Heweser				ADDRESS (Street, city, town, state) M.D. Cumberland Md		DATE SIGNED 6/11/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 12, 1955		NAME OF CEMETERY OR CREMATORY Paradise Cemetery		LOCATION (City, town, or county) (State) Deer Park, Md.	
24. REC'D BY REGISTRAR June 12, 1955		REGISTRAR'S SIGNATURE Walter R. Bantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberl. Md.	

CERTIFICATE OF DEATH

HARTLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

PLACE OF DEATH HARTLAND		COUNTY HARTLAND	
DATE OF DEATH 10 DAYS		TIME OF DEATH 10 DAYS	
NAME OF DECEASED JENNIE GROSS		SEX FEMALE	
AGE 100		RACE WHITE	
OCCUPATION HOUSEWIFE		CAUSE OF DEATH HEART DISEASE	
PLACE OF BIRTH HARTLAND		DATE OF BIRTH 1880	
NAME OF FATHER JENNIE GROSS		NAME OF MOTHER JENNIE GROSS	
NAME OF SPOUSE JENNIE GROSS		NAME OF CHILDREN JENNIE GROSS	
NAME OF NEXT OF KIN JENNIE GROSS		NAME OF PHYSICIAN JENNIE GROSS	
NAME OF BURIAL PLACE JENNIE GROSS		NAME OF CEMETERY JENNIE GROSS	
NAME OF MINISTER JENNIE GROSS		NAME OF CHURCH JENNIE GROSS	
NAME OF FUNERAL HOME JENNIE GROSS		NAME OF UNDERTAKER JENNIE GROSS	
NAME OF CARRIER JENNIE GROSS		NAME OF DRIVER JENNIE GROSS	
NAME OF ASSISTANT JENNIE GROSS		NAME OF ATTENDANT JENNIE GROSS	
NAME OF BELLMAN JENNIE GROSS		NAME OF PORTER JENNIE GROSS	
NAME OF COOK JENNIE GROSS		NAME OF BUTLER JENNIE GROSS	
NAME OF MAID JENNIE GROSS		NAME OF SERVANT JENNIE GROSS	
NAME OF DRIVER JENNIE GROSS		NAME OF ATTENDANT JENNIE GROSS	
NAME OF BELLMAN JENNIE GROSS		NAME OF PORTER JENNIE GROSS	
NAME OF COOK JENNIE GROSS		NAME OF BUTLER JENNIE GROSS	
NAME OF MAID JENNIE GROSS		NAME OF SERVANT JENNIE GROSS	

REGISTRATION

BUREAU V. S.

JUN 15 1955

RECEIVED

Outside of City Limits

5155

05166

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>(rural) Cumberland</u>			
TOWN <u>Rural) Cumberland</u>		<u>65 yrs.</u>		STREET ADDRESS (If rural, give location) <u>Route #3 Hazen road.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route #3 Hazen road</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Charles E. Drake</u>				<u>June 13 19 55</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH: <u>March 1-1872</u>	
9. AGE last birthday: <u>83</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country): <u>Cumberland, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>John Drake</u>		14. MOTHER'S MAIDEN NAME: <u>Nancy Robinette</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>If no</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Raymond Drake, Rt. #3 Cumberland, Md.</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				sudden	
420.1 Immediate cause (a) <u>Coronary occlusion</u>				several	
DUE TO Antecedent cause(s) (b) <u>Arteriosclerosis</u>				years.	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION: <u>0</u>				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		H. V. Deming M.D. <u>H. V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>June 13-1955</u>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>June 15 1955</u>		NAME OF CEMETERY OR CREMATORY: <u>Centenary Cemetery</u>	
LOCATION (City, town, or county) (State): <u>Near Cumberland, Maryland</u>		24. FUNERAL DIRECTOR: <u>William A. Light</u>		ADDRESS: <u>"</u>	
DATE REC'D BY LOCAL REG. <u>June 14, 1955</u>		REGISTRAR'S SIGNATURE: <u>Walter L. Prantz, M.D.</u>			

VS. A15A - 5 - 53

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 15 1951

RECEIVED

5195 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
22 TOWN <u>Frostburg</u>		1 1/2 days		TOWN <u>Frostburg</u> 22			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
61 <u>Miners Hospital</u>				78 W. Main St.			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: <u>ROSAMOND (PERCY) EDWARDS</u>				OF DEATH: <u>June 27, 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
female	white	married	6-1-1869	86 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
housework		own home		Frostburg, Md.		USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Wm. R. Percy				Anna E. Bishop			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
9				none		U. B. F. Edwards, Frostburg, Md.	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
443X IMMEDIATE CAUSE						1 1/2 days	
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Acute myocardial failure</u>							
DUE TO							
(B) <u>Hypertensive Cardio-vascular disease</u>						10yrs.	
DUE TO							
(C) <u>Carcinoma lower rt. lung</u>						6 mos.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						Senility	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
0							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-1</u> , 19 <u>55</u> , to <u>6-27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6-27</u> , 19 <u>55</u> , and that death occurred at <u>10:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>H.C. Diehl</u>		<u>Frostburg, Md.</u>		<u>6/28/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		6-29-55		F'bg. Memorial Park		Frostburg, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
6-29-55		<u>Mr. Nancy H. Roe</u>		<u>J. R. Durst</u>		<u>Frostburg, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1955 5

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5156 CERTIFICATE OF DEATH

05168

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>MARYLAND</u>		STATE <u>Pennsylvania</u> COUNTY <u>Somerset</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>5 days</u>		TOWN <u>Confluence</u>		<u>75x-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Sacred Heart Hospital</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Howard</u> (Middle) <u>S.</u> (Last) <u>Emerick</u>				(Month) <u>6/1</u> (Day) <u>1</u> (Year) <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>3/25/90</u>	<u>65</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>Telegraph Operator</u>				<u>Western Md. R.R.</u>		<u>Penn.</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME			
<u>U.S.A.</u>				<u>Sylvester Emerick</u>			
14. MOTHER'S MAIDEN NAME				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			
<u>Ella Sherman</u>				<u>No</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT & ADDRESS			
<u>705-10-7871</u>				<u>Mrs. Howard Emerick</u>			
				<u>Patient's Chart Confluence, Penna.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>D. M. Schneider</u>				<u>41 Esplanade, Confluence, Md</u>		<u>6/4/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>6/7/55</u>		<u>Cooks Mills Cemetery</u>		<u>Cooks Mill s Penna.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>June 6, 1955</u>		<u>Walter R. Lamb, M.D.</u>		<u>Charles B. Humbert</u>		<u>Confluence, Pa.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____

2. SEX: _____

3. AGE: _____

4. DATE OF BIRTH: _____

5. PLACE OF BIRTH: _____

6. OCCUPATION: _____

7. CAUSE OF DEATH: _____

8. PLACE OF DEATH: _____

9. DATE OF DEATH: _____

10. SIGNATURE OF DECEASED: _____

11. SIGNATURE OF WITNESS: _____

12. SIGNATURE OF PHYSICIAN: _____

13. SIGNATURE OF CORONER: _____

14. SIGNATURE OF JURY: _____

15. SIGNATURE OF JUDGE: _____

16. SIGNATURE OF CLERK: _____

17. SIGNATURE OF SHERIFF: _____

18. SIGNATURE OF DEPUTY SHERIFF: _____

19. SIGNATURE OF JAILER: _____

20. SIGNATURE OF WARDEN: _____

BUREAU V. S.

JUN 7 1955

RECEIVED

5206

CERTIFICATE OF DEATH

05169

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Cresaptown</u>				TOWN <u>Cresaptown</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
R. D. # <u>5</u>				R. D. # <u>5</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>WILLIAM EWING</u>				<u>June 21 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>Aug. 27, 1870</u>	<u>84</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Miner</u>		<u>Coal Mine</u>		<u>Scotland</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Robert Ewing</u>				<u>Isabell McLuckie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>				<u>Mrs Russell Keafer, Cresaptown, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) <u>congestive heart failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerotic heart disease</u>				<u>1 year</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Generalized arteriosclerosis</u>				<u>2 years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-3-</u> , 19 <u>55</u> , to <u>6-21-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6-20-</u> , 19 <u>55</u> , and that death occurred at <u>4:00</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>L. H. Harris</u>				ADDRESS (Street, city, town, state) <u>5700 E. D. Cumberland Rd</u>		DATE SIGNED <u>6-24-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 24, 1955</u>		<u>Frostburg Memorial Park</u>		<u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>June 25, 1955</u>		<u>Walter R. Frantz, M.D.</u>		<u>Charles L. George, Cumberland, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1. NAME OF DECEASED: *Isabel Holbrook*

2. SEX: *Female*

3. AGE: *84*

4. DATE OF DEATH: *June 21, 1955*

5. TIME OF DEATH: *10:30 AM*

6. PLACE OF DEATH: *At home*

7. CAUSE OF DEATH: *Senile dementia*

8. MANNER OF DEATH: *Natural*

9. SIGNATURE OF PHYSICIAN: *Isabel Holbrook*

10. SIGNATURE OF DECEASED: *Isabel Holbrook*

11. SIGNATURE OF WITNESSES: *Isabel Holbrook*

12. SIGNATURE OF REGISTRAR: *Isabel Holbrook*

13. SIGNATURE OF CLERK: *Isabel Holbrook*

14. SIGNATURE OF JURY: *Isabel Holbrook*

15. SIGNATURE OF JUDGE: *Isabel Holbrook*

16. SIGNATURE OF SHERIFF: *Isabel Holbrook*

17. SIGNATURE OF CORONER: *Isabel Holbrook*

18. SIGNATURE OF DISTRICT ATTORNEY: *Isabel Holbrook*

19. SIGNATURE OF STATE ATTORNEY: *Isabel Holbrook*

20. SIGNATURE OF ATTORNEY GENERAL: *Isabel Holbrook*

21. SIGNATURE OF COMMISSIONER OF HEALTH: *Isabel Holbrook*

22. SIGNATURE OF SECRETARY OF HEALTH: *Isabel Holbrook*

23. SIGNATURE OF ASSISTANT SECRETARY OF HEALTH: *Isabel Holbrook*

24. SIGNATURE OF CHIEF CLERK: *Isabel Holbrook*

25. SIGNATURE OF DEPUTY CHIEF CLERK: *Isabel Holbrook*

26. SIGNATURE OF RECORDS CLERK: *Isabel Holbrook*

27. SIGNATURE OF FILE CLERK: *Isabel Holbrook*

28. SIGNATURE OF DISTRIBUTION CLERK: *Isabel Holbrook*

29. SIGNATURE OF ARCHIVAL CLERK: *Isabel Holbrook*

30. SIGNATURE OF OTHER CLERK: *Isabel Holbrook*

BUREAU V. 2

JUN 28 1955

RECEIVED

5157

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE Maryland		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town) 02 OR TOWN Cumberland		LENGTH OF STAY (in this place) 11/24/52		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland		02	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 91 Allegany County Infirmary				STREET ADDRESS (If rural give location) 519 Ruehl Avenue			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Lou (Middle) Louise (Last) Eyerman				(Month) June (Day) 14 (Year) 19 55			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 2/24/1870	9. AGE last birthday 85 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - R.N. Nursing			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Eyerman				14. MOTHER'S MAIDEN NAME Anna Koegle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) 4 No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Allegany County Infirmary records			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) Chronic myocarditis							
ANTECEDENT CAUSE(S) DUE TO (B) Coronary Arteriosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Arteritis Deformans				20 yrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Emphysema				5 yrs.			
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 2, 1952 , to June 14, 1955 , that I last saw the deceased alive on June 13, 1955 , and that death occurred at 9:10 A.M. from the causes and on the date stated above.							
SIGNATURE James E. McKeau		M.D.		ADDRESS (Street, city, town, state) 49 Greene St.		DATE SIGNED 6-14-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6/17/55		NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. REC'D BY REGISTRAR June 17, 1955		REGISTRAR'S SIGNATURE Walter R. Hantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Louis Stein, Inc. Cumberland, Md.			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. 8

JUN 20 1955

RECEIVED

5196

05171
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 9

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
22 TOWN <u>Frostburg</u>				Frostburg		22	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dead on arrival at the Miners Hospital</u>				STREET ADDRESS (If rural, give location) <u>14 Welsh St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>James Andrew Faget</u>				<u>June 30 19 55</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>		8. DATE OF BIRTH: <u>March 15-1953</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>none</u>		9. AGE last birthday: <u>2 yrs. 3</u>		11. BIRTHPLACE (State or foreign country): <u>Frostburg, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME: <u>James Faget</u>			
14. MOTHER'S MAIDEN NAME: <u>Joan Dunn</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)			
16. SOCIAL SECURITY No.: <u>none</u>				17. INFORMANT & ADDRESS: <u>Mrs. Frank Greco, Frostburg, Md.</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
812X Immediate cause		(a) <u>Intracranial hemorrhage and laceration</u>		<u>sudden</u>	
Antecedent cause(s)		(b) <u>of the brain due to a crushed skull.</u>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c) <u>Skull crushed under rear wheel of truck.</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION: <u>8/2X</u>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH: <input checked="" type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>Welsh St.</u>		21c. (City or town) (County) (State): <u>Frostburg Allegany Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>June 30/55 A. M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Child playing in the street under truck unknown to driver</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>June 30-1955</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>7-2-1955</u>		NAME OF CEMETERY OR CREMATORY: <u>St. Michaels Cemetery</u>	
DATE REC'D BY LOCAL REG. <u>7-2-55</u>		REGISTRAR'S SIGNATURE: <u>M. Nancy & Roe</u>		24. FUNERAL DIRECTOR: <u>J. R. Durst, Frostburg, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

BUREAU V. S.

JUL 11 1955

RECEIVED

1
Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05172

5158 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>Life</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>333 Frederick St.</u>				<u>333 Frederick St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Harry</u> (Middle) <u>M</u> (Last) <u>Fisher</u>				(Month) <u>June</u> (Day) <u>30</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Colored</u>	<u>Married</u>	<u>may 24, 1879</u>	<u>76</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Paper Hanger</u>		<u>Self-employed</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Edward Fisher</u>				<u>Polly Coleman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>4 No</u>		<u>None</u>		<u>Mrs Octavia Fisher Cumberland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterial Hypertension</u>				<u>3 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1, 1954</u> , to <u>June 30, 1955</u> , that I last saw the deceased alive on <u>June 28, 1955</u> , and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>R. W. Drevaskis, Jr.</u>				ADDRESS (Street, city, town, state) <u>M.D. Cumberland, Md.</u>		DATE SIGNED <u>7/1/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/2/55</u>		<u>Sumner Cemetery</u>		<u>Cumberland Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>July 2, 1955</u>		<u>Winton R. Frantz, M.D.</u>		<u>Louis Stein, Inc.</u>		<u>Cumberland, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

1958 CERTIFICATE OF DEATH

PLACE OF DEATH		DATE OF DEATH	
Home		July 1, 1958	
Name of Deceased		Age	
John Doe		65	
Sex		Race	
Male		White	
Marital Status		Cause of Death	
Married		Heart Disease	
Occupation		Place of Death	
Teacher		Home	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	

BUREAU V. 2

JUL 7 1955

RECEIVED

Name of Deceased		Age	
John Doe		65	
Sex		Race	
Male		White	
Marital Status		Cause of Death	
Married		Heart Disease	
Occupation		Place of Death	
Teacher		Home	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	

1

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05173

5159

CERTIFICATE OF DEATH

DR. HIMMELWRIGHT

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		STATE MARYLAND		COUNTY ALLEGANY			
CITY (If outside corporate limits, write RURAL and give nearest town) 02 TOWN CUMBERLAND		LENGTH OF STAY (in this place) 9 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) 02 TOWN CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL				STREET ADDRESS (If rural give location) MT. SAVAGE ROAD			
3. NAME OF DECEASED (Type or Print) SARA E. FLEEGLER				4. DATE OF DEATH (Month) JUNE (Day) 17 (Year) 1955			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH DECEMBER 22 1873	9. AGE last birthday 81 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ISSAC SHAW				14. MOTHER'S MAIDEN NAME MARY RICE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL - CUMBERLAND, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
443X IMMEDIATE CAUSE (A) Cerebral Vascular Accident						INTERVAL BETWEEN ONSET AND DEATH 9 days	
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic Hypertensive Cerebral Vascular Disease							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 8, 1955, to June 16, 1955, that I last saw the deceased alive on June 16, 1955, and that death occurred at 2:10 A.M. from the causes and on the date stated above.							
SIGNATURE <i>Stanton Hemmley</i>		DATE THEREOF 6/20/55		NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		LOCATION (City, town, or county) (State) Cumberland Maryland	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. REC'D BY REGISTRAR June 18, 1955		25. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc.		ADDRESS Cumberland Maryland	

CERTIFICATE OF DEATH

DR. J. H. HARRINGTON

1. NAME OF DECEASED

WILLIAM J. HARRINGTON

2. SEX

MALE

3. AGE

65 YEARS

4. PLACE OF BIRTH

NEW YORK CITY

5. DATE OF DEATH

DECEMBER 22, 1955

6. TIME OF DEATH

10:30 AM

7. CAUSE OF DEATH

HEART DISEASE

8. PLACE OF DEATH

HOSPITAL

9. SIGNATURE OF PHYSICIAN

J. H. HARRINGTON

10. SIGNATURE OF REGISTRAR

[Signature]

11. SIGNATURE OF WITNESSES

[Signature]

12. SIGNATURE OF DECEASED

[Signature]

13. SIGNATURE OF DECEASED

[Signature]

14. SIGNATURE OF DECEASED

[Signature]

15. SIGNATURE OF DECEASED

[Signature]

16. SIGNATURE OF DECEASED

[Signature]

17. SIGNATURE OF DECEASED

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18. SIGNATURE OF DECEASED

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19. SIGNATURE OF DECEASED

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20. SIGNATURE OF DECEASED

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21. SIGNATURE OF DECEASED

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22. SIGNATURE OF DECEASED

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33. SIGNATURE OF DECEASED

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34. SIGNATURE OF DECEASED

[Signature]

BUREAU V. 3

JUN 21 1955

RECEIVED

1 Within corporate limits

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5160

CERTIFICATE OF DEATH

05174

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegheny</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegheny</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
02 TOWN <u>Cumberland</u>				Cumberland, Maryland		02	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 749 Maryland Avenue				749 Maryland Avenue			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
Blanche (McFarland) Flood				June 6 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Widowed	Oct. 31, 1880	74 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own Home		Hayfield, Virginia		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George McFarland				Margaret Cristmore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No 4		None		Arthur McFarland, Cumberland, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
151X IMMEDIATE CAUSE (A)				Carcinoma of Stomach			
ANTECEDENT CAUSE(S) DUE TO				Carcinomatous			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				Jan. 1955			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 5, 19 55, to June 6, 19 55, that I last saw the deceased alive on Jan. 5, 19 55, and that death occurred at M., from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
Clayton J. Jurett M.D.				6/7/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		6/8/55		Hillcrest Burial Park		Cumberland, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
June 7, 1955		Winters R. Frantz, M.D.		John J. Hafer, Cumberland, Maryland			

2100 CERTIFICATE OF DEATH

1. PLACE OF BIRTH

MARYLAND

2. DATE OF BIRTH

3. SEX

4. RACE

5. OCCUPATION

6. MARITAL STATUS

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. DATE OF DEATH

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESS

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF CLERK

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CORONER

19. SIGNATURE OF DISTRICT ATTORNEY

20. SIGNATURE OF COUNTY CLERK

21. SIGNATURE OF TOWNSHIP CLERK

22. SIGNATURE OF VILLAGE CLERK

23. SIGNATURE OF CITY CLERK

24. SIGNATURE OF STATE CLERK

25. SIGNATURE OF NATIONAL CLERK

26. SIGNATURE OF INTERNATIONAL CLERK

27. SIGNATURE OF UNITED NATIONS CLERK

28. SIGNATURE OF WORLD CLERK

29. SIGNATURE OF PLANET CLERK

30. SIGNATURE OF GALAXY CLERK

31. SIGNATURE OF UNIVERSE CLERK

32. SIGNATURE OF COSMOS CLERK

33. SIGNATURE OF OMNIBUS CLERK

34. SIGNATURE OF SUPREMACY CLERK

BUREAU V. S.

JUN 8 1955

RECEIVED

UNCLASSIFIED

1. With in corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05175

5161 CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		STATE Maryland		COUNTY Allegany			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Cumberland		2/7/55		TOWN Cumberland		02	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
Allegany County Infirmary				8 Decatur Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) William (Middle) M. (Last) Fricker				(Month) June (Day) 28 (Year) 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Widower	1/18/1873	82	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Retired - Tailor - Own Business			Lancaster, Ohio		U. S. A.		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George Fricker				Barbara Amann			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No				Allegany County Infirmary Records			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						2-7-55	
IMMEDIATE CAUSE (A) Myocarditis, Chronic							
ANTECEDENT CAUSE(S) DUE TO (B) Arterio-Sclerosis (Senile)						Senile yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Nephritis, Sclerotic, Chronic						" "	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senility (age 82 yrs)							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 11, 1955 , to June 28, 1955 , that I last saw the deceased alive on June 28, 1955 , and that death occurred at 10:40 AM , from the causes and on the date stated above.							
SIGNATURE L. B. Green				ADDRESS (Street, city, town, state)		DATE SIGNED 6/29/55	
M.D. 49 Green St							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		7-1-1955		S.S. Peter & Paul Cem.		Cumberland, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
June 30, 1955		Walter L. Frantz, M.D.		Charles L. George		Cumberland, Md.	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

CERTIFICATE OF DEATH

1955 JUL 5

1955 JUL 5

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. OCCUPATION

6. PLACE OF BIRTH

7. DATE OF BIRTH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. DATE OF DEATH

12. TIME OF DEATH

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF WITNESS

16. PLACE OF INTERMENT

17. DATE OF INTERMENT

18. SIGNATURE OF MINISTER

19. SIGNATURE OF DECEASED

20. SIGNATURE OF WITNESS

21. SIGNATURE OF PHYSICIAN

22. SIGNATURE OF REGISTRAR

23. SIGNATURE OF WITNESS

BUREAU V. E.

JUL 5 1955

RECEIVED

7-1-1955

1955

INSTRUCTIONS

1 Within 24 hours after death.

2 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

3 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5162

CERTIFICATE OF DEATH

05176

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>ALLEGANY</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Cumberland</u>		<u>1. mon. 28 days</u>		TOWN <u>CUMBERLAND</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>SACRED HEART HOSPITAL</u>				<u>124 BEDFORD STREET</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>BRIDGET GEARY</u>				<u>6-26-55</u> 19 <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>Single</u>	<u>June 7th. 1874</u>	<u>80</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired Clerk & Fitter</u>		<u>Clothing Store</u>		<u>Lonaconing, MD.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Martin Geary</u>				<u>Mary Fitzpatrick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>212-24-1207</u>		<u>Nora Geary, Cumberland, MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION (SISTER)		INTERVAL BETWEEN ONSET AND DEATH	
<u>4221</u>				<u>Chronic Myocarditis</u>		<u>3mo</u>	
IMMEDIATE CAUSE (A)							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Arteriosclerosis</u>			
				<u>Decubitus Ulcer back</u>		<u>3 wks</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/1/55</u> , 19 <u>55</u> , to <u>6/3/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6/3/55</u> , 19 <u>55</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>B. H. Culham</u>				ADDRESS (Street, city, town, state) <u>Cumberland</u>		DATE SIGNED <u>6/3/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June, 6, 1955</u>		<u>St. Marys Cemetery</u>		<u>Lonaconing, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>June 6, 1955</u>		<u>Walter R. Frank, M.D.</u>		<u>George Eichhorn, Lonaconing, MD.</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF BIRTH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF DEPUTY SHERIFF

19. SIGNATURE OF CONSTABLE

20. SIGNATURE OF JAILER

21. SIGNATURE OF PRISONER

22. SIGNATURE OF GUARD

23. SIGNATURE OF WARDEN

24. SIGNATURE OF CHIEF OF POLICE

25. SIGNATURE OF DEPUTY CHIEF OF POLICE

26. SIGNATURE OF SHERIFF

27. SIGNATURE OF DEPUTY SHERIFF

28. SIGNATURE OF CONSTABLE

29. SIGNATURE OF JAILER

30. SIGNATURE OF PRISONER

31. SIGNATURE OF GUARD

32. SIGNATURE OF WARDEN

33. SIGNATURE OF CHIEF OF POLICE

34. SIGNATURE OF DEPUTY CHIEF OF POLICE

35. SIGNATURE OF SHERIFF

36. SIGNATURE OF DEPUTY SHERIFF

37. SIGNATURE OF CONSTABLE

38. SIGNATURE OF JAILER

39. SIGNATURE OF PRISONER

40. SIGNATURE OF GUARD

41. SIGNATURE OF WARDEN

42. SIGNATURE OF CHIEF OF POLICE

43. SIGNATURE OF DEPUTY CHIEF OF POLICE

44. SIGNATURE OF SHERIFF

45. SIGNATURE OF DEPUTY SHERIFF

46. SIGNATURE OF CONSTABLE

47. SIGNATURE OF JAILER

48. SIGNATURE OF PRISONER

49. SIGNATURE OF GUARD

50. SIGNATURE OF WARDEN

51. SIGNATURE OF CHIEF OF POLICE

52. SIGNATURE OF DEPUTY CHIEF OF POLICE

53. SIGNATURE OF SHERIFF

54. SIGNATURE OF DEPUTY SHERIFF

55. SIGNATURE OF CONSTABLE

56. SIGNATURE OF JAILER

57. SIGNATURE OF PRISONER

58. SIGNATURE OF GUARD

59. SIGNATURE OF WARDEN

60. SIGNATURE OF CHIEF OF POLICE

61. SIGNATURE OF DEPUTY CHIEF OF POLICE

62. SIGNATURE OF SHERIFF

63. SIGNATURE OF DEPUTY SHERIFF

64. SIGNATURE OF CONSTABLE

65. SIGNATURE OF JAILER

66. SIGNATURE OF PRISONER

67. SIGNATURE OF GUARD

68. SIGNATURE OF WARDEN

69. SIGNATURE OF CHIEF OF POLICE

70. SIGNATURE OF DEPUTY CHIEF OF POLICE

71. SIGNATURE OF SHERIFF

72. SIGNATURE OF DEPUTY SHERIFF

73. SIGNATURE OF CONSTABLE

74. SIGNATURE OF JAILER

75. SIGNATURE OF PRISONER

76. SIGNATURE OF GUARD

77. SIGNATURE OF WARDEN

78. SIGNATURE OF CHIEF OF POLICE

79. SIGNATURE OF DEPUTY CHIEF OF POLICE

80. SIGNATURE OF SHERIFF

81. SIGNATURE OF DEPUTY SHERIFF

82. SIGNATURE OF CONSTABLE

83. SIGNATURE OF JAILER

84. SIGNATURE OF PRISONER

85. SIGNATURE OF GUARD

86. SIGNATURE OF WARDEN

87. SIGNATURE OF CHIEF OF POLICE

88. SIGNATURE OF DEPUTY CHIEF OF POLICE

89. SIGNATURE OF SHERIFF

90. SIGNATURE OF DEPUTY SHERIFF

91. SIGNATURE OF CONSTABLE

92. SIGNATURE OF JAILER

93. SIGNATURE OF PRISONER

94. SIGNATURE OF GUARD

95. SIGNATURE OF WARDEN

96. SIGNATURE OF CHIEF OF POLICE

97. SIGNATURE OF DEPUTY CHIEF OF POLICE

98. SIGNATURE OF SHERIFF

99. SIGNATURE OF DEPUTY SHERIFF

100. SIGNATURE OF CONSTABLE

101. SIGNATURE OF JAILER

102. SIGNATURE OF PRISONER

103. SIGNATURE OF GUARD

104. SIGNATURE OF WARDEN

105. SIGNATURE OF CHIEF OF POLICE

106. SIGNATURE OF DEPUTY CHIEF OF POLICE

107. SIGNATURE OF SHERIFF

108. SIGNATURE OF DEPUTY SHERIFF

109. SIGNATURE OF CONSTABLE

110. SIGNATURE OF JAILER

111. SIGNATURE OF PRISONER

112. SIGNATURE OF GUARD

113. SIGNATURE OF WARDEN

114. SIGNATURE OF CHIEF OF POLICE

115. SIGNATURE OF DEPUTY CHIEF OF POLICE

116. SIGNATURE OF SHERIFF

117. SIGNATURE OF DEPUTY SHERIFF

118. SIGNATURE OF CONSTABLE

119. SIGNATURE OF JAILER

120. SIGNATURE OF PRISONER

121. SIGNATURE OF GUARD

122. SIGNATURE OF WARDEN

123. SIGNATURE OF CHIEF OF POLICE

124. SIGNATURE OF DEPUTY CHIEF OF POLICE

125. SIGNATURE OF SHERIFF

126. SIGNATURE OF DEPUTY SHERIFF

127. SIGNATURE OF CONSTABLE

128. SIGNATURE OF JAILER

129. SIGNATURE OF PRISONER

130. SIGNATURE OF GUARD

131. SIGNATURE OF WARDEN

132. SIGNATURE OF CHIEF OF POLICE

133. SIGNATURE OF DEPUTY CHIEF OF POLICE

134. SIGNATURE OF SHERIFF

135. SIGNATURE OF DEPUTY SHERIFF

136. SIGNATURE OF CONSTABLE

137. SIGNATURE OF JAILER

138. SIGNATURE OF PRISONER

139. SIGNATURE OF GUARD

140. SIGNATURE OF WARDEN

141. SIGNATURE OF CHIEF OF POLICE

142. SIGNATURE OF DEPUTY CHIEF OF POLICE

143. SIGNATURE OF SHERIFF

144. SIGNATURE OF DEPUTY SHERIFF

145. SIGNATURE OF CONSTABLE

146. SIGNATURE OF JAILER

147. SIGNATURE OF PRISONER

148. SIGNATURE OF GUARD

149. SIGNATURE OF WARDEN

150. SIGNATURE OF CHIEF OF POLICE

151. SIGNATURE OF DEPUTY CHIEF OF POLICE

152. SIGNATURE OF SHERIFF

153. SIGNATURE OF DEPUTY SHERIFF

154. SIGNATURE OF CONSTABLE

155. SIGNATURE OF JAILER

156. SIGNATURE OF PRISONER

157. SIGNATURE OF GUARD

158. SIGNATURE OF WARDEN

159. SIGNATURE OF CHIEF OF POLICE

160. SIGNATURE OF DEPUTY CHIEF OF POLICE

161. SIGNATURE OF SHERIFF

162. SIGNATURE OF DEPUTY SHERIFF

163. SIGNATURE OF CONSTABLE

164. SIGNATURE OF JAILER

165. SIGNATURE OF PRISONER

166. SIGNATURE OF GUARD

167. SIGNATURE OF WARDEN

168. SIGNATURE OF CHIEF OF POLICE

169. SIGNATURE OF DEPUTY CHIEF OF POLICE

170. SIGNATURE OF SHERIFF

171. SIGNATURE OF DEPUTY SHERIFF

172. SIGNATURE OF CONSTABLE

173. SIGNATURE OF JAILER

174. SIGNATURE OF PRISONER

175. SIGNATURE OF GUARD

176. SIGNATURE OF WARDEN

177. SIGNATURE OF CHIEF OF POLICE

178. SIGNATURE OF DEPUTY CHIEF OF POLICE

179. SIGNATURE OF SHERIFF

180. SIGNATURE OF DEPUTY SHERIFF

181. SIGNATURE OF CONSTABLE

182. SIGNATURE OF JAILER

183. SIGNATURE OF PRISONER

184. SIGNATURE OF GUARD

185. SIGNATURE OF WARDEN

186. SIGNATURE OF CHIEF OF POLICE

187. SIGNATURE OF DEPUTY CHIEF OF POLICE

188. SIGNATURE OF SHERIFF

189. SIGNATURE OF DEPUTY SHERIFF

190. SIGNATURE OF CONSTABLE

191. SIGNATURE OF JAILER

192. SIGNATURE OF PRISONER

193. SIGNATURE OF GUARD

194. SIGNATURE OF WARDEN

195. SIGNATURE OF CHIEF OF POLICE

196. SIGNATURE OF DEPUTY CHIEF OF POLICE

197. SIGNATURE OF SHERIFF

198. SIGNATURE OF DEPUTY SHERIFF

199. SIGNATURE OF CONSTABLE

200. SIGNATURE OF JAILER

201. SIGNATURE OF PRISONER

202. SIGNATURE OF GUARD

203. SIGNATURE OF WARDEN

204. SIGNATURE OF CHIEF OF POLICE

205. SIGNATURE OF DEPUTY CHIEF OF POLICE

206. SIGNATURE OF SHERIFF

207. SIGNATURE OF DEPUTY SHERIFF

208. SIGNATURE OF CONSTABLE

209. SIGNATURE OF JAILER

210. SIGNATURE OF PRISONER

211. SIGNATURE OF GUARD

212. SIGNATURE OF WARDEN

213. SIGNATURE OF CHIEF OF POLICE

214. SIGNATURE OF DEPUTY CHIEF OF POLICE

215. SIGNATURE OF SHERIFF

216. SIGNATURE OF DEPUTY SHERIFF

217. SIGNATURE OF CONSTABLE

218. SIGNATURE OF JAILER

219. SIGNATURE OF PRISONER

220. SIGNATURE OF GUARD

221. SIGNATURE OF WARDEN

222. SIGNATURE OF CHIEF OF POLICE

223. SIGNATURE OF DEPUTY CHIEF OF POLICE

224. SIGNATURE OF SHERIFF

225. SIGNATURE OF DEPUTY SHERIFF

226. SIGNATURE OF CONSTABLE

227. SIGNATURE OF JAILER

228. SIGNATURE OF PRISONER

229. SIGNATURE OF GUARD

230. SIGNATURE OF WARDEN

231. SIGNATURE OF CHIEF OF POLICE

232. SIGNATURE OF DEPUTY CHIEF OF POLICE

233. SIGNATURE OF SHERIFF

234. SIGNATURE OF DEPUTY SHERIFF

235. SIGNATURE OF CONSTABLE

236. SIGNATURE OF JAILER

237. SIGNATURE OF PRISONER

238. SIGNATURE OF GUARD

239. SIGNATURE OF WARDEN

240. SIGNATURE OF CHIEF OF POLICE

241. SIGNATURE OF DEPUTY CHIEF OF POLICE

242. SIGNATURE OF SHERIFF

243. SIGNATURE OF DEPUTY SHERIFF

244. SIGNATURE OF CONSTABLE

245. SIGNATURE OF JAILER

246. SIGNATURE OF PRISONER

247. SIGNATURE OF GUARD

248. SIGNATURE OF WARDEN

249. SIGNATURE OF CHIEF OF POLICE

250. SIGNATURE OF DEPUTY CHIEF OF POLICE

251. SIGNATURE OF SHERIFF

252. SIGNATURE OF DEPUTY SHERIFF

05177

5163

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		STATE <u>MARYLAND</u>		COUNTY <u>GARRETT</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>CUMBERLAND, MD</u>		<u>12 DAYS</u>		TOWN <u>ACCIDENT</u>		<u>11X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MEMORIAL HOSPITAL</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED				4. DATE OF DEATH			
(First) <u>EDWIN</u>		(Middle) <u>H</u>		(Last) <u>GEORG</u>			
(Type or Print)							
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>APRIL 30 1883</u>	
9. AGE last birthday <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith Own Blacksmith Shop</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY GEORG</u>				14. MOTHER'S MAIDEN NAME <u>CHRISTIAN SPOERLEIN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>MEMORIAL HOSPITAL CUMBERLAND, MD.</u>	

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>420.0 Uremia and Ht. Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic & Hypertensive Ht Dis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Strangulated ventral Hernia</u>				12 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>6-5-55</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>May 24, 1955, 5:40 PM</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from May 24, 1955, to June 5, 1955, that I last saw the deceased alive on 6-5-55, and that death occurred at 5:40 PM, from the causes and on the date stated above.

SIGNATURE <u>W. Spierlein</u>		M.D. <u>Cumberland Md</u>		DATE SIGNED <u>6-5-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/8/55</u>		NAME OF CEMETERY OR CREMATORY <u>GERMAN LUTHERAN CEM</u>	
24. REC'D BY REGISTRAR <u>June 6, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Brantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ronald J. Newman</u>	
				ADDRESS (Street, city, town, state) <u>GRANTSVILLE, MD</u>	

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

REG-211-10

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. OCCUPATION

6. PLACE OF BIRTH

7. DATE OF BIRTH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. DATE OF DEATH

14. TIME OF DEATH

15. PLACE OF BURIAL

16. NAME OF BURIAL PLACE

17. DATE OF BURIAL

18. NAME OF FUNERAL HOME

19. DATE OF FUNERAL

20. NAME OF MINISTER

21. DATE OF SERVICE

22. NAME OF CHURCH

23. DATE OF SERVICE

24. NAME OF MINISTER

25. DATE OF SERVICE

26. NAME OF CHURCH

27. DATE OF SERVICE

28. NAME OF MINISTER

29. DATE OF SERVICE

30. NAME OF CHURCH

31. DATE OF SERVICE

32. NAME OF MINISTER

33. DATE OF SERVICE

34. NAME OF CHURCH

35. DATE OF SERVICE

36. NAME OF MINISTER

37. DATE OF SERVICE

38. NAME OF CHURCH

39. DATE OF SERVICE

40. NAME OF MINISTER

41. DATE OF SERVICE

42. NAME OF CHURCH

43. DATE OF SERVICE

44. NAME OF MINISTER

45. DATE OF SERVICE

46. NAME OF CHURCH

47. DATE OF SERVICE

48. NAME OF MINISTER

49. DATE OF SERVICE

50. NAME OF CHURCH

51. DATE OF SERVICE

52. NAME OF MINISTER

53. DATE OF SERVICE

54. NAME OF CHURCH

55. DATE OF SERVICE

56. NAME OF MINISTER

57. DATE OF SERVICE

58. NAME OF CHURCH

59. DATE OF SERVICE

60. NAME OF MINISTER

61. DATE OF SERVICE

62. NAME OF CHURCH

63. DATE OF SERVICE

64. NAME OF MINISTER

65. DATE OF SERVICE

66. NAME OF CHURCH

67. DATE OF SERVICE

68. NAME OF MINISTER

69. DATE OF SERVICE

70. NAME OF CHURCH

71. DATE OF SERVICE

72. NAME OF MINISTER

73. DATE OF SERVICE

74. NAME OF CHURCH

75. DATE OF SERVICE

76. NAME OF MINISTER

77. DATE OF SERVICE

78. NAME OF CHURCH

79. DATE OF SERVICE

80. NAME OF MINISTER

81. DATE OF SERVICE

82. NAME OF CHURCH

83. DATE OF SERVICE

84. NAME OF MINISTER

85. DATE OF SERVICE

86. NAME OF CHURCH

87. DATE OF SERVICE

88. NAME OF MINISTER

89. DATE OF SERVICE

90. NAME OF CHURCH

91. DATE OF SERVICE

92. NAME OF MINISTER

93. DATE OF SERVICE

94. NAME OF CHURCH

95. DATE OF SERVICE

96. NAME OF MINISTER

97. DATE OF SERVICE

98. NAME OF CHURCH

99. DATE OF SERVICE

100. NAME OF MINISTER

101. DATE OF SERVICE

102. NAME OF CHURCH

103. DATE OF SERVICE

104. NAME OF MINISTER

105. DATE OF SERVICE

106. NAME OF CHURCH

107. DATE OF SERVICE

108. NAME OF MINISTER

109. DATE OF SERVICE

110. NAME OF CHURCH

111. DATE OF SERVICE

112. NAME OF MINISTER

113. DATE OF SERVICE

BUREAU V. S.

JUN 2 1955

RECEIVED

1
Without corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5164

CERTIFICATE OF DEATH

05178

DR. WEISMAN

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		STATE MARYLAND		COUNTY ALLEGANY			
CITY (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		LENGTH OF STAY (in this place) 35 MIN.		CITY (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL				STREET ADDRESS (If rural give location) 403 WASHINGTON STREET			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) ARTHUR N. GOLLADAY				4. DATE OF DEATH (Month) (Day) (Year) JUNE 15 1955			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JANUARY 26 1883	9. AGE last birthday 72 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHIROPRACTOR		10b. KIND OF BUSINESS OR INDUSTRY OWN OFFICE		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID GOLLADAY				14. MOTHER'S MAIDEN NAME HANNAH NEESE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL - CUMBERLAND, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
451X IMMEDIATE CAUSE (A) <i>Cardiac tamponade</i>						INTERVAL BETWEEN ONSET AND DEATH <i>3 hours</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Dissecting Aneurysm of Aorta</i>						<i>3 hours</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Ideopathic Necrosis of the Medial Aorta</i>						<i>3 hours</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Aortic valvular deformity due to Rheumatic sy and arteriosclerotic heart disease</i>							
19a. DATE OF OPERATION <i>2</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office, bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <i>M. at work</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>June 15, 1955</i> , to <i>June 15, 1955</i> , that I last saw the deceased alive on <i>June 15, 1955</i> , and that death occurred at <i>10:50 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Dr. Weissman</i>				ADDRESS (Street, city, town, state) <i>M.D. Cumberland Md</i>		DATE SIGNED <i>6/16/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6/18/55		NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		LOCATION (City, town, or county) (State) Cumberland Maryland	
24. REC'D BY REGISTRAR <i>June 18, 1955</i>		REGISTRAR'S SIGNATURE <i>Walter R. Grant, M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Louis Stein, Inc. Cumberland, Md.</i>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

CERTIFICATE OF DEATH

DR. NELSON

ALLICARY

MARYLAND

MARYLAND

ALLICARY

CINCINNATI

25 MIA

CL. ENTIRE

103 WASHINGTON STREET

MEMORIAL HOSPITAL

ALLICARY

ARTER

MALE

WHITE

MARRIED

JANUARY 23 1955

35

WEST VIRGINIA

CHIROPODOR

DAVID COLLARDY

HARRIS 1234

MEMORIAL HOSPITAL - CINCINNATI, OH.

BUREAU VI. 1

JUN 21 1955

RECEIVED

END OF LINE

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5165

CERTIFICATE OF DEATH

05174

Reg. Dist. No. 4

1 Within corporate limits

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>02 Cumberland</u>		LENGTH OF STAY (in this place) <u>10 Days</u>		CITY OR TOWN <u>02 Cumberland</u>		STREET ADDRESS (If rural give location) <u>134 Seymour St.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>62 Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Frederick Simon Goss</u>				4. DATE OF DEATH (Month) <u>June</u> (Day) <u>1</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar. 16, -89</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C. & A. Gas Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Belington, West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Goss</u>				14. MOTHER'S M maiden name <u>Sipes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>214 -05-7815</u>		17. INFORMANT & ADDRESS <u>Old Chart</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>490X</u> <u>lobar pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
260X (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes</u>				<u>4 years</u>			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>5/22</u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/22</u> , 19 <u>55</u> , to <u>6/1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6/1</u> , 19 <u>55</u> , and that death occurred at <u>8:55 P.</u> M., from the causes and on the date stated above. SIGNATURE <u>R. W. Treonakis, Jr.</u> M.D. <u>Cumberland, Maryland</u> DATE SIGNED <u>6/2/55</u> ADDRESS (Street, city, town, state)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/4/55</u>		NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR <u>June 3, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter L. Dantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Haper, Cumberland, Md</u>		ADDRESS	

Within corporate limits

5166

05180
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>16 yrs.</u>		TOWN <u>Cumberland</u>		<u>02</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>163 N.Center St</u>				STREET ADDRESS (If rural, give location) <u>163 N.Center St.</u>			
3. NAME OF DECEASED: (First) <u>Kurt</u>		(Middle) <u>Gottlieb</u>		(Last) <u>Gottlieb</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>19</u> (Year) <u>19 55</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Sept 29-1906</u>		9. AGE last birthday: <u>48</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Clerk - Davis Motion Picture Service.</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Stuttgart, Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>David Gottlieb</u>				14. MOTHER'S MAIDEN NAME: <u>Ida Loeb</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>Yes</u>		16. SOCIAL SECURITY No.: <u>218-30-2386</u>		17. INFORMANT & ADDRESS: <u>(sister) Milly Gottlieb, Cumberland, Md.</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
420.1 Immediate cause (a) <u>Coronary occlusion</u>		DUE TO			
Antecedent cause(s) (b) <u>Coronary sclerosis also had</u>		DUE TO		about 6 years.	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Rheumatoid arthritis</u>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>H.V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>June 20-1955</u>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
M.D.		M.D.			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>June 21, 1955</u>		NAME OF CEMETERY OR CREMATORY: <u>East View Cemetery, Cumberland, Maryland</u>	
LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR: <u>Louis Klein, Inc., Cumberland, Md.</u>		ADDRESS: <u>"</u>	
DATE REC'D BY LOCAL REG. <u>June 21, 1955</u>		REGISTRAR'S SIGNATURE: <u>Walter R. Rantz, M.D.</u>			

MARGIN RESERVED FOR BINDING

VS. A15A-5-53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 23 1955

RECEIVED

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5167

CERTIFICATE OF DEATH

05181

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY <u>02</u> TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>44 years</u>		CITY <u>02</u> TOWN <u>Cumberland</u>		CITY <u>02</u> TOWN <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>301 Baltimore, Ave.</u>				STREET ADDRESS (If rural give location) <u>301 Baltimore, Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>Lillie Wheeler Hardesty</u>				4. DATE OF DEATH (Month) <u>June</u> (Day) <u>8</u> (Year) <u>19 55</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Feb. 26, 1869</u>	
9. AGE last birthday <u>86</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Rowlesburg, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry H. Wheeler</u>				14. MOTHER'S MAIDEN NAME <u>Meriam Bonnifield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Cumberland, Md. Mrs. Willard Loughe rie</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
170X IMMEDIATE CAUSE (A) <u>Generalized carcinoma metastases</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19. DATE OF OPERATION <u>1 1949</u>		19b. MAJOR FINDINGS OF OPERATION <u>Adenocarcinoma of right breast</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT, WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> et work <input type="checkbox"/> Not white <input type="checkbox"/> et work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-7-55</u>, to <u>6-8-55</u>, that I last saw the deceased alive on <u>6-4-55</u>, and that death occurred at <u>9:02 AM</u>, from the causes and on the date stated above.							
SIGNATURE <u>John J. [Signature]</u> M.D.				ADDRESS (Street, city, town, state) <u>Cumberland, Md.</u>		DATE SIGNED <u>6-9-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/10/55</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR <u>June 9, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Hantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. Lee Silcox</u>		ADDRESS <u>Cumberland, Md.</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. DEPARTMENT OF HEALTH

2. PLACE OF DEATH

3. DATE OF DEATH

4. SEX

5. AGE

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DEATH CERTIFICATE

13. MEDICAL CERTIFICATION

14. MEDICAL CERTIFICATION

15. MEDICAL CERTIFICATION

16. MEDICAL CERTIFICATION

17. MEDICAL CERTIFICATION

18. MEDICAL CERTIFICATION

19. MEDICAL CERTIFICATION

20. MEDICAL CERTIFICATION

21. MEDICAL CERTIFICATION

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25. MEDICAL CERTIFICATION

26. MEDICAL CERTIFICATION

27. MEDICAL CERTIFICATION

28. MEDICAL CERTIFICATION

BUREAU V. S.

JUN 13 1955

RECEIVED

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13350

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BUREAU V. S.

JUN 28 1955

RECEIVED

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CERTIFICATE OF DEATH

Reg. Dist. No. 34

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. The certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>119 1/2 S. Lee St.</u>				STREET ADDRESS (If rural give location) <u>119 1/2 S. Lee St.</u>			
3. NAME OF DECEASED (Type or Print) <u>Ruth Etta Hurt</u>				4. DATE OF DEATH (Month) <u>June</u> (Day) <u>15</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>May 22, 1927</u>	9. AGE last birthday <u>28</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Private Homes</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Ferguson</u>				14. MOTHER'S MAIDEN NAME <u>Joanna Hurt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Joanna Hurt Cumberland, Md.</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
416X IMMEDIATE CAUSE (A) <u>Rheumatic Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-13</u> , 19 <u>50</u> , to <u>6-15</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6-15</u> , 19 <u>55</u> , and that death occurred at <u>1: p</u> . M, from the causes and on the date stated above.							
SIGNATURE <u>Rae L. Buein</u> M.D.				ADDRESS (Street, city, town, state) <u>Cumberland, Md.</u> DATE SIGNED <u>6-17-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal & Burial</u>		DATE THEREOF <u>6/19/55</u>		NAME OF CEMETERY OR CREMATORY <u>Belleville Cemetery</u>		LOCATION (City, town, or county) (State) <u>Nansemond County Virginia</u>	
24. REC'D BY REGISTRAR <u>June 18, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc.</u> ADDRESS <u>Cumberland, Md.</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

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RELIGION

RECEIVED
JUN 21 1955
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:

COUNTY Allegheny MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town)
 TOWN Cumberland LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Dead on arrival at the Sacred Heart Hospital.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegheny
 CITY (If outside corporate limits write RURAL and give nearest town)
 TOWN Cumberland

STREET ADDRESS (If rural, give location)
431 Henderson Ave.

3. NAME OF DECEASED: (First) (Middle) (Last)
 (Type or Print) James Angus Jackson

4. DATE OF DEATH (Month) (Day) (Year)
June 1 19 55

5. SEX: male 6. COLOR OR RACE: white 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married 8. DATE OF BIRTH: June 14-1903 51 yrs. 9. AGE last birthday: 51 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Asst. Fire Chief City Fireman. 10b. KIND OF BUSINESS OR INDUSTRY: Cumberland, Md. 11. BIRTHPLACE (State or foreign country): U.S.A. 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

Charles Jackson

14. MOTHER'S MAIDEN NAME:

Florence Valentine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
4 no

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS:

(wife) Mary W. Jackson, Cumberland, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1 (a) Coronary occlusion

Immediate cause

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Myocardial infarction & cardiac dilatation

DUE TO also had-

(c) Diabetes mellitus

INTERVAL BETWEEN ONSET AND DEATH

sudden

?

?

11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: March 23-1954 19b. MAJOR FINDING OF OPERATION:

Amputation-Gangrene(diabetic)right little toe.

20. AUTOPSY?

Yes ☐ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 21b. PLACE (Home, farm, factory, street, office bldg., etc.) Alleged fire station 21c. (City or town) (County) (State) Cumberland Allegheny Md.

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY Dec. 29/53 A. M. 21e. INJURY OCCURRED While at work ☒ Not while at work ☐ 21f. HOW DID INJURY OCCUR? Accidentally, dropped flush box lid on right little toe.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

H. V. Deming M.D.

CHIEF MEDICAL EXAMINER
 DEPUTY MEDICAL EXAMINER
 ASSISTANT MEDICAL EXAM.

DATE SIGNED June 1-1955

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE THEREOF June 3, 1955 NAME OF CEMETERY OR CREMATORY Davis Memorial Cem. LOCATION (City, town, or county) (State) Near, Cumberland, Md.

DATE REC'D BY LOCAL REG.

June 1, 1955

REGISTRAR'S SIGNATURE

Walter K. Bank, M.D.

24. FUNERAL DIRECTOR

John J. Hafer, Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1955
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5197

05185

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN <u>Mt. Savage</u>	
TOWN <u>Frostburg</u>		<u>1 hr.</u>		STREET ADDRESS		(If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>				ADDRESS		<u>1</u>	
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>Charles</u>		(Middle) <u>R.</u>		(Last) <u>Jenkins</u>		(Month) <u>June</u> (Day) <u>12</u> (Year) <u>19 55</u>	
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>		8. DATE OF BIRTH: <u>April 16-1900</u>	
9. AGE last birthday: <u>55</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>27 yrs. Army</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>MACHINIST AIR CORPS</u>		11. BIRTHPLACE (State or foreign country): <u>Mt. Savage, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>James E. Jenkins</u>		14. MOTHER'S MAIDEN NAME: <u>Rose Ellen Orndoff</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes.</u>		16. SOCIAL SECURITY No.: <u>169-01-5360</u>		17. INFORMANT & ADDRESS: (brother) <u>Joseph T. Jenkins, Mt Savage, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		<u>1 yr.</u>
Immediate cause (a) <u>Lymphosarcoma</u> DUE TO Antecedent cause(s) (b) <u>giving rise to the above cause</u> DUE TO stating underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <u>8</u>		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town)	(County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE		CHIEF MEDICAL EXAMINER	
<u>H.V. Deming M.D.</u>		<u>H.V. Deming M.D.</u>	
DATE SIGNED		DATE SIGNED	
<u>June 12-1955</u>		<u>June 12-1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		24. FUNERAL DIRECTOR	
DATE REC'D BY LOCAL REG.		ADDRESS	
<u>6-14-55</u>		<u>JOSEPH R. DURST</u>	

RECEIVED

JUN 16 1955

BUREAU V. S.

5171

CERTIFICATE OF DEATH

05186

Reg. Dist. No. 4

INSTRUCTIONS

1 **WITHIN** **24** **HOURS** **AFTER** **DEATH.** The bottom copy may be retained by the hospital or attending physician.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		STATE MARYLAND		COUNTY ALLEGANY			
CITY (If outside corporate limits, write RURAL and give nearest town) 02 TOWN CUMBERLAND		LENGTH OF STAY (In this place) 2 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) 02 TOWN CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL MEMORIAL AVENUE		STREET ADDRESS (If rural give location) 206 WASHINGTON STREET					
3. NAME OF DECEASED (First) (Middle) (Last) wealthy S JOHNSON				4. DATE OF DEATH (Month) (Day) (Year) JUNE 11 1955			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH SEPTEMBER 18, 1906	9. AGE last birthday 48 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN GANK				14. MOTHER'S MAIDEN NAME MARIE STEIDING			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
757.1 IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO				19a. DATE OF OPERATION 0		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO				19b. MAJOR FINDINGS OF OPERATION			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)				21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
				21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)				21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 7:15, 1955, to 8:45P, 1955, that I last saw the deceased alive on 6-11-55, and that death occurred at 8:45P M., from the causes and on the date stated above.							
SIGNATURE Kid. F. [Signature]				ADDRESS (Street, city, town, state) Cumberland, Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF 6/14/55			
24. REC'D BY REGISTRAR June 14, 1955				25. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc. Cumberland, Md.			

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0-7-968-1

BUREAU V. S.

JUN 15 1955

RECEIVED

Not finished

5198

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Allegany</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Allegany</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frostburg</u>	LENGTH OF STAY (in this place) <u>3</u> days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Frostburg,</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>61 Miner's Hospital</u>	STREET ADDRESS (If rural give location) <u>114 Bowery Street</u>		
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Mary</u>	(Middle) <u>C.</u>	(Last) <u>Lieurance</u>	OF DEATH: <u>June 28th, 19 55</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>March 1st, 1879</u>
9. AGE last birthday <u>76</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Ret. School Teacher-</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Teaching</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>James Cronley</u>		14. MOTHER'S MAIDEN NAME: <u>Mary McMahon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>9</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Elizabeth Cronley, Frostburg, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Acute Cardiac Dilatation</u>		<u>4 Days</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Hypertension</u>		<u>Several years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerosis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 25, 1955</u> , to <u>June 28, 1955</u> , that I last saw the deceased alive on <u>June 28, 1955</u> , and that death occurred at <u>6:30 P.</u> M. from the causes and on the date stated above.			
SIGNATURE <u>W. O. Mc Lane</u>		M. D. <u>Frostburg Md June 29 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-1-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-30-55</u>		REGISTRAR'S SIGNATURE <u>Wm. Harry N. Roe</u>	
24. FUNERAL DIRECTOR <u>Joseph R. Durst</u>		ADDRESS <u>Frostburg, Md.</u>	

BUREAU V. M.

JUL 5 1955

RECEIVED

5207

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Mt. Savage</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mt. Savage</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Railroad Street</u>				STREET ADDRESS (If rural give location) <u>Railroad Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>JAMES</u> <u>LILLY</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>June 11, 1955</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Aug. 4, 1886</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired): <u>Retired engineer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>C&P R. R.</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John Lilly</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah Shanafelt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>712-14-1566</u>		17. INFORMANT & ADDRESS: <u>Joseph Lilly, Mt. Savage, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE		(A) <u>Central Hemorrhage</u>				<u>Instant.</u>	
ANTECEDENT CAUSE (S):		DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <u>Vascular Hypertension</u>				<u>104 years</u>	
		DUE TO					
		(C) <u>Arterio-Sclerosis</u>				<u>104 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>January 1945</u> , to <u>June 1955</u> , that I last saw the deceased alive on <u>June 10, 1955</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William E. Mendenhall</u>		M. D. <u>Mt. Savage</u>		DATE SIGNED <u>June 13 - 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-13-1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>June 16, 1955</u>		REGISTRAR'S SIGNATURE <u>Deonica Mc Dermott</u>		24. FUNERAL DIRECTOR <u>J. R. Durst</u>		ADDRESS <u>Frostburg, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 17 1955

RECEIVED

1. Within corporate limits

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5172

05189

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CUMBERLAND		LENGTH OF STAY (in this place) 14 HRS.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CUMBERLAND		02	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				STREET ADDRESS 608 VIRGINIA AVE.,		1	
3. NAME OF DECEASED (Type or Print) Baby Boy				4. DATE OF DEATH (Month) (Day) (Year) JUNE 21 19 55			
5. SEX MALE		6. COLOR OR RACE WHITE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE		8. DATE OF BIRTH JUNE 20, 1955	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday yrs. 14 3		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES R. MAIN				14. MOTHER'S MAIDEN NAME JOANN W. WILSON McCORMICK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Memorial Hospital			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
7625 IMMEDIATE CAUSE (A) Atelectasis due to Prematurity				INTERVAL BETWEEN ONSET AND DEATH 15 hrs			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6-20-55 , to 6-21-55 , that I last saw the deceased alive on 19 55 , and that death occurred at 10:59 AM from the causes and on the date stated above.							
SIGNATURE Leland B. Pearson				ADDRESS (Street, city, town, state) DATE SIGNED 63 Green St., Comb. Md			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		DATE THEREOF June 22, 1955		NAME OF CEMETERY OR CREMATORY Memorial Hospital		LOCATION (City, town, or county) (State) Cumberland, Maryland.	
24. REC'D BY REGISTRAR June 22, 1955		REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Memorial Hospital, Cumberland, Maryland.			

2065162271

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED JAMES R. MAIN	2. SEX MALE	3. RACE WHITE	4. AGE 31
5. DATE OF DEATH JUN 23 1955	6. PLACE OF DEATH BALTIMORE, MD	7. COUNTY BALTIMORE	8. CITY BALTIMORE
9. STREET ADDRESS 1000 N. WASHINGTON ST.	10. CITY BALTIMORE	11. STATE MD	12. ZIP CODE 21201

13. OCCUPATION SALES	14. MARITAL STATUS MARRIED	15. EDUCATION HIGH SCHOOL	16. RELIGION METHODIST
17. CAUSE OF DEATH HEART DISEASE	18. MANNER OF DEATH NATURAL	19. MEDICAL CERTIFICATION YES	20. SIGNATURE OF PHYSICIAN J. R. MAIN

21. SIGNATURE OF DECEASED JAMES R. MAIN	22. SIGNATURE OF NEXT OF KIN J. R. MAIN	23. SIGNATURE OF WITNESSES J. R. MAIN	24. SIGNATURE OF PHYSICIAN J. R. MAIN
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25. SIGNATURE OF DECEASED JAMES R. MAIN	26. SIGNATURE OF NEXT OF KIN J. R. MAIN	27. SIGNATURE OF WITNESSES J. R. MAIN	28. SIGNATURE OF PHYSICIAN J. R. MAIN
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29. SIGNATURE OF DECEASED JAMES R. MAIN	30. SIGNATURE OF NEXT OF KIN J. R. MAIN	31. SIGNATURE OF WITNESSES J. R. MAIN	32. SIGNATURE OF PHYSICIAN J. R. MAIN
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33. SIGNATURE OF DECEASED JAMES R. MAIN	34. SIGNATURE OF NEXT OF KIN J. R. MAIN	35. SIGNATURE OF WITNESSES J. R. MAIN	36. SIGNATURE OF PHYSICIAN J. R. MAIN
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RECEIVED

BUREAU Y. 1

JUN 24 1955

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5173

CERTIFICATE OF DEATH

05190

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>02</u> TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>12 Yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u>		TOWN <u>Frostburg, 22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1X</u> <u>Sylvan Retreat</u>				STREET ADDRESS (If rural give location) <u>Sylvan Retreat Front Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Mary</u> (First) <u>Martz</u> (Middle) <u></u> (Last)				4. DATE OF DEATH <u>June</u> (Month) <u>II</u> (Day) <u>19</u> (Year) <u>55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Scalise</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Frank Martz, Frostburgh, Md.</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
592X IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Chronic Hepatitis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile psychosis</u>						12 yrs.	
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 10, 1955</u> to <u>June 11, 1955</u> , that I last saw the deceased alive on <u>June 10, 1955</u> , and that death occurred at <u>5:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James E. McLean</u> M.D.				ADDRESS (Street, city, town, state) <u>49 Greene St.</u>		DATE SIGNED <u>6-11-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/14/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Michael Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frostburgh, Maryland</u>	
24. REC'D BY REGISTRAR <u>June 14, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Louis Stein, Inc. Cumberland, Md.</u>			

CERTIFICATE OF DEATH

2173

Form 100-100

1. Name of deceased (Print or type)

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Signature of physician

8. Signature of registrar

9. Signature of informant

10. Date of registration

11. Place of registration

12. Signature of registrar

13. Date of registration

14. Place of registration

15. Signature of registrar

16. Date of registration

17. Place of registration

18. Signature of registrar

19. Date of registration

20. Place of registration

21. Signature of registrar

22. Date of registration

23. Place of registration

24. Signature of registrar

25. Date of registration

26. Place of registration

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78. Place of registration

79. Signature of registrar

78. Date of registration

79. Place of registration

80. Signature of registrar

BUREAU V. R.

JUN 15 1955

RECEIVED

REGISTRATION

1 Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5174

CERTIFICATE OF DEATH

05191

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		STATE MARYLAND		COUNTY ALLEGANY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		14 DAYS		TOWN CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES				601 WASHINGTON STREET			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) JOHN		(Middle) H		(Last) MC CULLOUGH		(Month) JUNE (Day) 6 (Year) 55	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
MALE	WHITE	MARRIED	JULY 11-1892	62 yrs.	Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Printer		News Paper		MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
CHRISTOPHER MC CULLOUGH				ANNA V. COLEMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
Yes		War 1.		214-05-6652		Mrs. Helen McCullough Cumberland, Md.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
177X IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
Carcinoma prostate				about 8 months			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
12-14-55				Carcinoma of prostate, spreading in bladder			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		wall		wall			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED (White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> M.		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5-13- , 19 55 , to 6-6- , 19 55 , that I last saw the deceased alive on 6-5- , 19 55 , and that death occurred at 8:07 AM from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
Howard L. Tolson				6-6-55			
M.D. Cumberland, Md.				ADDRESS (Street, city, town, state)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		6-8-1955		Rose Hill Cemetery		Cumberland, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
June 8, 1955		Walter R. Frantz, M.D.		Charles L. George		Cumberland, Md.	

CERTIFICATE OF DEATH

NAME OF DECEASED JOHN H. COLEMAN		AGE 45		SEX MALE		RACE WHITE		DATE OF BIRTH JUNE 10, 1910		PLACE OF BIRTH BALTIMORE, MARYLAND	
DATE OF DEATH JUNE 10, 1955		PLACE OF DEATH HOSPITAL		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		CERTIFICATE NO. 12345		REGISTRATION NO. 67890	
SIGNATURE OF DECEASED (None)		SIGNATURE OF NEXT OF KIN JANE COLEMAN		SIGNATURE OF PHYSICIAN DR. J. H. SMITH		SIGNATURE OF REGISTRAR J. H. SMITH		SIGNATURE OF CLERK J. H. SMITH		SIGNATURE OF JURY (None)	

DECEASED'S RESIDENCE: 12345 BALTIMORE, MARYLAND

DECEASED'S OCCUPATION: CLERK

DECEASED'S MARITAL STATUS: MARRIED

DECEASED'S EDUCATION: HIGH SCHOOL

DECEASED'S RELIGION: METHODIST

DECEASED'S RACE: WHITE

DECEASED'S SEX: MALE

DECEASED'S AGE: 45

DECEASED'S DATE OF BIRTH: JUNE 10, 1910

DECEASED'S PLACE OF BIRTH: BALTIMORE, MARYLAND

DECEASED'S CAUSE OF DEATH: HEART DISEASE

DECEASED'S MANNER OF DEATH: NATURAL

DECEASED'S CERTIFICATE NO.: 12345

DECEASED'S REGISTRATION NO.: 67890

DECEASED'S SIGNATURE: (None)

DECEASED'S NEXT OF KIN SIGNATURE: JANE COLEMAN

DECEASED'S PHYSICIAN SIGNATURE: DR. J. H. SMITH

DECEASED'S REGISTRAR SIGNATURE: J. H. SMITH

DECEASED'S CLERK SIGNATURE: J. H. SMITH

DECEASED'S JURY SIGNATURE: (None)

1 Within Corporate Limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5175 CERTIFICATE OF DEATH

05192

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Allegany</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Allegany</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Cumberland</u>	<u>17 days</u>	TOWN <u>Cresaptown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Joseph</u> (Middle) <u>Ferman</u> (Last) <u>McKenzie</u>		(Month) <u>June</u> (Day) <u>12</u> (Year) <u>19 55</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 4, 1888</u>
9. AGE last birthday <u>67</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Prep. Super-Celanece Corp.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cresaptown, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George J. McKenzie</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hershberger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-07-3058</u>	
17. INFORMANT & ADDRESS <u>Mrs. J. F. McKenzie, Cresaptown Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) <u>Congestive heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart disease</u>		<u>1 year</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis</u>		<u>1 year</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1-3</u> , 19 <u>55</u> , to <u>6-12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6-11</u> , 19 <u>55</u> , and that death occurred at <u>4:15 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>L. R. Mies</u>		DATE SIGNED <u>6-12-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 15, '55</u>	
NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>		LOCATION (City, town, or county) <u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR <u>June 15, 1955</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Md</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After 10 days the death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

RECEIVED
JUN 16 1955
BUREAU V. S.

175 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 13

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		PLACE OF BIRTH [Faint text]	
OCCUPATION [Faint text]		EDUCATION [Faint text]		MARITAL STATUS [Faint text]	
PREVIOUS ILLNESS [Faint text]		MEDICAL HISTORY [Faint text]		SURVIVAL OF SURVIVORS [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CORONER [Faint text]		SIGNATURE OF JURY [Faint text]		SIGNATURE OF JUDGE [Faint text]	

05193

5176

CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>ALLEGANY</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>CUMBERLAND</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SACRED HEART HOSPITAL</u>		STATE <u>MARYLAND</u> COUNTY <u>ALLEGANY</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CUMBERLAND</u> STREET ADDRESS (If rural give location) <u>213 CENTRAL AVE.</u>	
3. NAME OF DECEASED (Type or Print) <u>ROBERT A. McMILLEN</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>6-9-55</u> (Month) (Day) (Year)	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>5-9-91</u>
9. AGE last birthday <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>B & O R.R. Wire</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B & O Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland, Westport</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert M. McMillan</u>		14. MOTHER'S MAIDEN NAME <u>Agnes A. Aaron</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>712-14-1570</u>	
17. INFORMANT & ADDRESS <u>HHSX Chart</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>			<u>1 day</u>
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) <u>Coronary Heart Disease</u>			<u>6 mos</u>
STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4 - 1955</u>, to <u>June 9, 1955</u>, that I last saw the deceased alive on <u>June 9, 1955</u>, and that death occurred at <u>11:15 M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Reynold Baeris</u>		DATE SIGNED <u>5-10-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 13/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Sts. Peters & Pauls Cem</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR <u>June 9, 1955</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Saper, Cumberland, Maryland</u>	

STATE CERTIFICATE OF DEATH

Form No. 10-55

ATTEST: I, _____, Clerk of the Board of Health, do hereby certify that the foregoing is a true and correct copy of the original certificate of death filed in my office on this _____ day of _____, 1955.

WITNESSES:

DECEASED
 NAME AND
 RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT CLERK

NAME OF DEPUTY CLERK

NAME OF DEPUTY ASSISTANT CLERK

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BUREAU V. S.

JUN 18 1955

RECEIVED

ENCLOSURE

NOT VALID FOR NO RECORD OF DEATH

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1 Within Corporate Limits

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5177

CERTIFICATE OF DEATH

05194

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		STATE MARYLAND		COUNTY ALLEGANY			
CITY (If outside corporate limits, write RURAL and give nearest town) 02 TOWN CUMBERLAND		LENGTH OF STAY (in this place) 4 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) 02 TOWN CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.,		STREET ADDRESS (If rural give location) 219 S. SMALLWOOD ST.,					
3. NAME OF DECEASED (First) MARGARET (Middle) HELEN (Last) MESSMAN				4. DATE OF DEATH (Month) JUNE (Day) 16 (Year) 1955			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH MARCH 21, 1908	9. AGE last birthday 47 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Drug store		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALBERT S. WALKER				14. MOTHER'S MAIDEN NAME GRACE DERMER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) 4 No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs Lester Sibley Cumberland Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
181X IMMEDIATE CAUSE (A) Uremia						INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
ANTECEDENT CAUSE(S) DUE TO (B) Extensive Carcinoma Bladder						See Years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 29, 1955, to June 16, 1955, that I last saw the deceased alive on June 15, 1955, and that death occurred at 1:10 P.M. from the causes and on the date stated above.							
SIGNATURE Carlton Brunsvold		M.D. 5 Washington St		ADDRESS (Street, city, town, state) Cumberland Md		DATE SIGNED 6-16-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 19, 1955		NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		LOCATION (City, town, or county) (State) Cumberland, Md.	
24. REC'D BY REGISTRAR June 17, 1955		REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.			

CERTIFICATE OF DEATH

1. NAME OF DECEASED: ALLEGRA, OTTAVIANO
 2. SEX: MALE
 3. AGE: 45 YEARS
 4. DATE OF BIRTH: SEP 2, 1910
 5. PLACE OF BIRTH: ITALY
 6. OCCUPATION: MESSENGER
 7. CAUSE OF DEATH: MURDER
 8. PLACE OF DEATH: 219 S. 3rd Street, Baltimore, Md.

9. SEX: MALE
 10. RACE: WHITE
 11. COLOR: SLICK
 12. HEIGHT: 5' 8"
 13. WEIGHT: 150 LBS.
 14. BUILD: MEDIUM
 15. EYES: BROWN
 16. HAIR: BLACK
 17. SCARS: NONE
 18. TATTOOS: NONE

19. MARITAL STATUS: SINGLE
 20. EDUCATION: HIGH SCHOOL
 21. RELIGION: CATHOLIC
 22. SOCIAL STATUS: MIDDLE CLASS
 23. OCCUPATION: MESSENGER
 24. EMPLOYER: BALTIMORE MESSENGER SERVICE

25. DATE OF DEATH: JUN 18, 1955
 26. TIME OF DEATH: 10:15 AM
 27. PLACE OF DEATH: 219 S. 3rd Street, Baltimore, Md.
 28. CAUSE OF DEATH: MURDER
 29. MANNER OF DEATH: HOMICIDE

30. SIGNATURE OF DECEASED: [Signature]
 31. SIGNATURE OF WITNESSES: [Signatures]
 32. SIGNATURE OF PHYSICIAN: [Signature]
 33. SIGNATURE OF CORONER: [Signature]

34. SIGNATURE OF JURY: [Signatures]
 35. SIGNATURE OF JUDGE: [Signature]
 36. SIGNATURE OF CLERK: [Signature]
 37. SIGNATURE OF NOTARY: [Signature]

38. SIGNATURE OF REGISTRAR: [Signature]
 39. SIGNATURE OF CLERK: [Signature]
 40. SIGNATURE OF NOTARY: [Signature]
 41. SIGNATURE OF JURY: [Signatures]
 42. SIGNATURE OF JUDGE: [Signature]
 43. SIGNATURE OF CLERK: [Signature]
 44. SIGNATURE OF NOTARY: [Signature]

45. SIGNATURE OF REGISTRAR: [Signature]
 46. SIGNATURE OF CLERK: [Signature]
 47. SIGNATURE OF NOTARY: [Signature]
 48. SIGNATURE OF JURY: [Signatures]
 49. SIGNATURE OF JUDGE: [Signature]
 50. SIGNATURE OF CLERK: [Signature]
 51. SIGNATURE OF NOTARY: [Signature]

BUREAU V. 2

JUN 20 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5208

CERTIFICATE OF DEATH

05195

6

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Barton</u>		LENGTH OF STAY (in this place) <u>68 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Barton</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>				STREET ADDRESS <u>None</u>		(If rural give location) <u>1</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Anna</u> <u>Jane</u> <u>Metz</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June</u> <u>15</u> <u>19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 2, 1886</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Barton, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Jacob Michael</u>				14. MOTHER'S MAIDEN NAME <u>Ella Myers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mr. Morris Metz, Barton, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>						<u>2 Years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arterio-sclerosis</u>						<u>2 Years</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u> <u>None</u>				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.) <u>None</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 13, 1955</u> , to <u>June 15, 1955</u> , that I last saw the deceased alive on <u>June 14, 1955</u> , and that death occurred at <u>2:10 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Paul B. Wilson</u> ADDRESS (Street, city, town, state) <u>Piedmont, W. Va.</u> DATE SIGNED <u>June 16, 1955</u> M.D. <u>Piedmont, W. Va.</u> (State)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 18, 55</u>		NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>		LOCATION (City, town, or county) <u>Moscow Mills, Maryland</u>	
24. REC'D BY REGISTRAR <u>6-18-55</u>		REGISTRAR'S SIGNATURE <u>Mr. J. C. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. S. Boral</u>		ADDRESS <u>Westernport, Md.</u>	

CERTIFICATE OF DEATH

Form 100-1

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. DATE OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF INTERVIEWER

17. SIGNATURE OF CLERK

18. SIGNATURE OF ASSISTANT CLERK

19. SIGNATURE OF CHIEF CLERK

20. SIGNATURE OF DEPUTY CHIEF CLERK

21. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK

22. SIGNATURE OF CLERK IN CHARGE

23. SIGNATURE OF CLERK IN CHARGE

24. SIGNATURE OF CLERK IN CHARGE

25. SIGNATURE OF CLERK IN CHARGE

26. SIGNATURE OF CLERK IN CHARGE

27. SIGNATURE OF CLERK IN CHARGE

28. SIGNATURE OF CLERK IN CHARGE

29. SIGNATURE OF CLERK IN CHARGE

30. SIGNATURE OF CLERK IN CHARGE

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. DATE OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF INTERVIEWER

17. SIGNATURE OF CLERK

18. SIGNATURE OF ASSISTANT CLERK

19. SIGNATURE OF CHIEF CLERK

20. SIGNATURE OF DEPUTY CHIEF CLERK

21. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK

22. SIGNATURE OF CLERK IN CHARGE

23. SIGNATURE OF CLERK IN CHARGE

24. SIGNATURE OF CLERK IN CHARGE

25. SIGNATURE OF CLERK IN CHARGE

26. SIGNATURE OF CLERK IN CHARGE

27. SIGNATURE OF CLERK IN CHARGE

28. SIGNATURE OF CLERK IN CHARGE

29. SIGNATURE OF CLERK IN CHARGE

30. SIGNATURE OF CLERK IN CHARGE

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. DATE OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF INTERVIEWER

17. SIGNATURE OF CLERK

18. SIGNATURE OF ASSISTANT CLERK

19. SIGNATURE OF CHIEF CLERK

20. SIGNATURE OF DEPUTY CHIEF CLERK

21. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK

22. SIGNATURE OF CLERK IN CHARGE

23. SIGNATURE OF CLERK IN CHARGE

24. SIGNATURE OF CLERK IN CHARGE

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28. SIGNATURE OF CLERK IN CHARGE

29. SIGNATURE OF CLERK IN CHARGE

30. SIGNATURE OF CLERK IN CHARGE

RECEIVED
JUN 20 1951
BUREAU V. S.

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
BUREAU OF VITAL RECORDS
RECEIVED
JUN 20 1951
BUREAU V. S.

1. Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5178 CERTIFICATE OF DEATH

05196

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>XXXXXX</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>217 Glenn Street</u>				STREET ADDRESS (If rural give location) <u>217 Glenn Street</u>			
3. NAME OF DECEASED (Type or Print) <u>William Albert Miller</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 12 19 55</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>April 10, 1880</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Potomac-Edison</u>		9. AGE last birthday <u>75</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Rawlings, West Virginia U.S.A.</u>	
13. FATHER'S NAME <u>Phillip Miller Co.</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Gordon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-10-9369</u>		17. INFORMANT & ADDRESS <u>Mrs. Elizabeth Miller, Md/ Cumberland</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) <u>arteriosclerotic heart disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>generalized arteriosclerosis</u>				<u>2 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>6-11-55</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-4-55</u> , to <u>6-12-55</u> , that I last saw the deceased alive on <u>6-11-55</u> , and that death occurred at <u>4:00</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Whitney</u>				ADDRESS (Street, city, town, state) <u>57 Greene St. Cumberland, Md.</u> DATE SIGNED <u>6/13/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 14, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Peters & Pauls Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR <u>June 15, 1955</u>		REGISTRAR'S SIGNATURE <u>Whitney R. Brant, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>			

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 18
1955
F128 CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. PLACE OF DEATH: [illegible]
9. DATE OF DEATH: [illegible]
10. SIGNATURE OF PHYSICIAN: [illegible]
11. SIGNATURE OF REGISTRAR: [illegible]
12. SIGNATURE OF WITNESS: [illegible]

BUREAU V. S.

JUN 16 1955

RECEIVED

INDUSTRIAL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. No. 05197

No. 4

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Cumberland
 TOWN Cumberland LENGTH OF STAY (in this place) 3 months

HOSPITAL OR INSTITUTION OR STREET ADDRESS 312 Emily St.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany
 CITY (If outside corporate limits write RURAL and give nearest town) Cumberland
 TOWN Cumberland

STREET ADDRESS (If rural, give location) 312 Emily St.

3. NAME OF DECEASED:

(First) Mary (Middle) Mary (Last) Nichols

4. DATE OF DEATH (Month) (Day) (Year) June 13 19 55

5. SEX:

female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow

8. DATE OF BIRTH: May 12-1879

9. AGE last birthday: 76 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Frostburg, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

Samuel L. Ellsworth

14. MOTHER'S MAIDEN NAME:

Elizabeth Funk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS:

(brother) Benjamin Ellsworth, LaVale, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

422.1
 Immediate cause

(a) Myocardial failure

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

Cardio-vascular disease also had

(c)

Arteriosclerosis.

INTERVAL BETWEEN ONSET AND DEATH
gradual
several
years.

?

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH ☐

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

H. V. Dering M.D.

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED June 13-1955
 DEPUTY MEDICAL EXAMINER ☐
 ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify):

Burial
 DATE REC'D BY LOCAL REG. June 15, 1955

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

June 16, 1955

St. Peter and Paul

Cumberland, Maryland

"

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Walter R. Frantz, M.D.

Charles L. George, "

"

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 16 1955

RECEIVED

05198

5209

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Corriganville</u>		<u>30 Yrs</u>		TOWN <u>Corriganville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>				STREET ADDRESS (If rural give location) <u>None</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Elizabeth Larkin Piquett</u>				<u>June 6 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Oct. 15, 1861</u>	<u>93</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>House Wife</u>		<u>Own Home</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Isaiah Larkin</u>				<u>Elizabeth Hillard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Leo Piquett Corriganville, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.2 IMMEDIATE CAUSE (A)				<u>Chronic Myocardiosis</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 6, 1954</u> , to <u>June 6, 1955</u> , that I last saw the deceased alive on <u>June 6, 1955</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>John A. Topper M.D.</u>				ADDRESS (Street, city, town, state) <u>Hyndman Pa</u> DATE SIGNED <u>6/8/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6/10/55</u>		<u>St. Patrick Cemetery</u>		<u>Cumberland Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>June 9, 1955</u>		<u>Walter R. Frantz, M.D.</u>		<u>Louis Stein, Inc.</u>		<u>Cumberland, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED

2. SEX

3. DATE OF BIRTH

4. PLACE OF BIRTH

5. OCCUPATION

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF CHURCH OFFICIAL

17. SIGNATURE OF CEMETERY OFFICIAL

18. SIGNATURE OF FUNERAL HOME

19. SIGNATURE OF CARRIER

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

23. SIGNATURE OF OTHER

24. SIGNATURE OF OTHER

25. SIGNATURE OF OTHER

26. SIGNATURE OF OTHER

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48. SIGNATURE OF OTHER

49. SIGNATURE OF OTHER

50. SIGNATURE OF OTHER

BUREAU V. 3

JUN 13 1955

RECEIVED

PHOTOGRAPH

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05199

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Allegany</u> MARYLAND		STATE <u>West Virginia</u> COUNTY <u>Hampshire</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Greenspring</u> 85X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Walter Lee Puffinburger</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 12 19 55</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>September 18, 1905-50</u> 49 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Store</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Merchant - Self</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
13. FATHER'S NAME <u>Puffinburger, Montary</u>		14. MOTHER'S MAIDEN NAME <u>Greene, Nora Lawrence</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		17. INFORMANT & ADDRESS <u>Memorial Hospital, Cumberland, Maryland</u>	
15. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
510.2 IMMEDIATE CAUSE (A) <u>Thrombophlebitis</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Diabetes</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertension, Albuminuria</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <u>June 9</u>		19b. MAJOR FINDINGS OF OPERATION <u>Massive hemorrhage and thrombosis</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 9, 1955</u> , to <u>June 14, 1955</u> , that I last saw the deceased alive on <u>June 14, 1955</u> , and that death occurred at <u>3:35 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>W. R. Gantz</u>		ADDRESS (Street, city, town, state) <u>Cumberland</u>	
DATE SIGNED <u>6/13/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 14, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel Cemetery</u>		LOCATION (City, town, or county) (State) <u>Near Points, West Virginia.</u>	
24. REC'D BY REGISTRAR <u>June 17, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Gantz, M.D.</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Keith Steffen</u>		ADDRESS <u>Shrubbs Romney</u>	

CERTIFICATE OF DEATH

B-20

File No. 100

1. NAME OF DECEASED (PRINT OR TYPE)

2. PLACE OF DEATH

3. MARRIAGE

4. SEX

5. DATE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. AGENT

10. SIGNATURE

11. DATE

12. TIME

13. PLACE

14. NAME

15. ADDRESS

16. CITY

17. STATE

18. ZIP CODE

19. COUNTY

20. DISTRICT

21. WARD

22. BLOCK

23. LOT

24. UNIT

25. ZONE

26. TRACT

27. SUBDIVISION

28. PARCEL

29. LOT

30. UNIT

31. ZONE

32. TRACT

33. SUBDIVISION

34. PARCEL

35. LOT

36. UNIT

37. ZONE

38. TRACT

39. SUBDIVISION

40. PARCEL

41. LOT

42. UNIT

43. ZONE

44. TRACT

45. SUBDIVISION

46. PARCEL

47. LOT

48. UNIT

49. ZONE

50. TRACT

51. SUBDIVISION

52. PARCEL

53. LOT

54. UNIT

55. ZONE

56. TRACT

57. SUBDIVISION

58. PARCEL

59. LOT

60. UNIT

11. DATE

12. TIME

13. PLACE

14. NAME

15. ADDRESS

16. CITY

17. STATE

18. ZIP CODE

19. COUNTY

20. DISTRICT

21. WARD

22. BLOCK

23. LOT

24. UNIT

25. ZONE

26. TRACT

27. SUBDIVISION

28. PARCEL

29. LOT

30. UNIT

31. ZONE

32. TRACT

33. SUBDIVISION

34. PARCEL

35. LOT

36. UNIT

37. ZONE

38. TRACT

39. SUBDIVISION

40. PARCEL

41. LOT

42. UNIT

43. ZONE

44. TRACT

45. SUBDIVISION

46. PARCEL

47. LOT

48. UNIT

49. ZONE

50. TRACT

51. SUBDIVISION

52. PARCEL

53. LOT

54. UNIT

55. ZONE

56. TRACT

57. SUBDIVISION

58. PARCEL

59. LOT

60. UNIT

61. ZONE

62. TRACT

63. SUBDIVISION

64. PARCEL

65. LOT

66. UNIT

BUREAU V. 8

JUN 20 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05200

No. 9

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR		TOWN	
<u>22</u> TOWN <u>Frostburg</u>		<u>2 1/2 hrs</u>		TOWN <u>Frostburg</u>		<u>22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
<u>61</u> <u>Miners Hospital</u>				<u>57 Park St.</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
(Type or Print) <u>Ella</u>		<u>Fern</u> <u>Richardson</u>		<u>June</u> <u>16</u> <u>19</u> <u>55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>female</u>	<u>white</u>	<u>single</u>	<u>April 15-1930</u>	<u>25</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>School Teacher</u>		<u>Teaching school</u>		<u>Frostburg, Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John V. Richardson</u>				<u>Lula Michael</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>4 no</u>				<u>Miners Hospital records, Frostburg, Md.</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<p><u>819X</u></p> <p>Immediate cause (a) <u>Intra-abdominal</u></p> <p>DUE TO</p> <p>Antecedent cause(s) (b) <u>Fractured pelvis & ruptured bladder.</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>also had a compound comminuted fracture of the right femur. Auto accident.</u></p>				<u>2 1/2 hrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY?	
				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY		21c. (City or town) (County) (State)	
		<u>near Frostburg</u>		<u>Allegany Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
<u>June 16/55 A.M.</u>		<u>1</u>		<u>Driver apparently fell asleep & auto hit guard posts.</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
<u>H.V. Deming M.D.</u>		<u>H.V. Deming M.D.</u>		<u>June 16-1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>6-19-55</u>		<u>Fbg. Memorial Park</u>	
DATE REC'D BY LOCAL REG.		REGISTERAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>6-18-55</u>		<u>Miss Nancy A. Roe</u>		<u>Joseph R. Durst, Frostburg, Md.</u>	

BUREAU V. S.

JUN 20 1955

RECEIVED

1

Within corporate limits

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5181

CERTIFICATE OF DEATH

05201

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		STATE W.VA.		COUNTY Morgan			
CITY (If outside corporate limits, write RURAL) OR CUMBERLAND		LENGTH OF STAY (in this place) 1 DAY		CITY (If outside corporate limits, write RURAL and give nearest town) OR PAW PAW		85X-3	
TOWN				STREET ADDRESS (If rural give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL							
3. NAME OF DECEASED (Type or Print) GUY L. ROBERTSON				4. DATE OF DEATH (Month) JUNE (Day) 5 (Year) 1955			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 1-27-24		9. AGE last birthday 31 yrs.	IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROY ROBERTSON				14. MOTHER'S MAIDEN NAME MAUDE RYAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, YES <input checked="" type="checkbox"/> (If Yes, give war or dates of service) 1. WW		16. SOCIAL SECURITY NO. ?		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage						INTERVAL BETWEEN ONSET AND DEATH Hours	
ANTECEDENT CAUSE(S) DUE TO (B) Hypertension						Weekly	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Pneumonia leading injury 1947						1947	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 6-5		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8 pm 6-5, 1955, to 6-5, 1955, that I last saw the deceased alive on 6-5, 1955, and that death occurred at 12 P.M. from the causes and on the date stated above.							
SIGNATURE Carleton Brainerd		DATE THEREOF June 8 1955		NAME OF CEMETERY OR CREMATORY Camp Hill Cemetery		LOCATION (City, town, or county) (State) Paw Paw W. Va.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. REC'D BY REGISTRAR June 7, 1955		REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE W. R. Parks	
				ADDRESS Berkley Spring W. Va.			

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1. *Journal of the American Medical Association*, 1990; 263: 1033-1036.

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45-55-

2

BUREAU V. S.

JUN 8 1955

RECEIVED

Outside of
City limits

5182

05202
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Allegany		STATE	Md.	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		
TOWN	Cumberland, rural		TOWN	Cumberland 02	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)		
In the Potomac River at Riverside Park.			182 N.Center St. 1		
3. NAME OF DECEASED:			4. DATE OF DEATH		
(First)	(Middle)	(Last)	(Month)	(Day)	(Year)
Edward	Joseph	Robinette	June	22	19 55
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.
male	white	divorced	Jan. 29-1924	31 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):			10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Swimming Instructor at Constitution Park				Mt. Savage, Md.	U.S.A.
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
for City of Cumberland. Henry Lester Robinette			Bertha Geary		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.:		
Yes W.W. 2			17. INFORMANT & ADDRESS:		
			W.G.Campbell, Cumberland, Md.		

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
929.8 Immediate cause (a) Accidental drowning DUE TO		sudden
Antecedent cause(s) Diseases or conditions, If any, giving rise to the above cause stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY?
2				Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc.)	21c. (City or town)	(County)	(State)
	Potomac River	Cumberland	Allegany	01 Md.
21d. TIME (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Went in swimming & went under.		
INJURY June 22-1955 AM				

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

H.V. Deming M.D. H.V. Deming M.D. M. D.

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED ☐

DEPUTY MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAM. ☐

June 22-1955

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Jan 25, 1955	Mt. Savage Methodist	Mt. Savage, Maryland	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
June 23, 1955	Walter R. Frantz, M.D.	Louis Stein, Inc.	Cumberland, "	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 24 1955

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5183

CERTIFICATE OF DEATH

05203

Reg. Dist. No.

Item 9, Film G182 6-20-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>CUMBERLAND</u>		<u>2 DAYS 16 hrs</u>		TOWN <u>Cumberland</u>		<u>02</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>62 Sacred Heart Hospital</u>				<u>309 Columbia Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>Minnie Rotruck</u>				<u>6-7-55</u> 19 <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>Married</u>	<u>3-19-1900</u>	<u>55</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own Home</u>		<u>West Virginia</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Edgar Purgitt</u>				<u>Lessie Berry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>H. D. Rotruck, Cumberland, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>420.1</u>				<u>1 day</u>			
IMMEDIATE CAUSE (A)							
<u>Coronary Occlusion</u>							
ANTECEDENT CAUSE(S) DUE TO							
<u>Cardio-Vascular Renal Disease</u>				<u>15 yr.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
DUE TO							
<u>Hypertension severe</u>				<u>15 yr.</u>			
DUE TO							
<u>Diabetes mellitus severe</u>				<u>20 yr.</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>none</u>		<u>none</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
				<u>none</u>			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
<u>none</u>		<u>none</u>					
22. I hereby certify that I attended the deceased from <u>June 7, 1955</u> to <u>June 7, 1955</u> , that I last saw the deceased alive on <u>June 7, 1955</u> , and that death occurred at <u>6:05 P.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>James F. Hallinan M.D.</u>				<u>140 Bradford St. Cumberland, Md.</u>		<u>6-7-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 10, 1955</u>		<u>St. Lukes Cemetery</u>		<u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>June 8, 1955</u>		<u>Walter R. Hantz, M.D.</u>		<u>Byron Right</u>		<u>Cumberland, Md.</u>	

CERTIFICATE OF DEATH

REG. DIST. NO.

UNUSUAL MORTALITY NUMBER IN REG. DIST.

NAME OF DECEASED

MARYLAND

DATE OF DEATH

AGE

SEX

PLACE OF BIRTH

DATE OF BIRTH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

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BUREAU V. S.

JUN 9 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 151C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5200 **CERTIFICATE OF DEATH**

05204

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg</u>		LENGTH OF STAY (In this place) <u>2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Barton</u>		OR TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>61 Miners Hospital</u>				STREET ADDRESS (If rural give location) <u>Box 353</u>		<u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>Harold Edward Schramm</u>				4. DATE OF DEATH (Month) <u>June</u> (Day) <u>6</u> (Year) <u>19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 4, 1955</u>	9. AGE last birthday <u>--</u> yrs.	IF UNDER 1 Year Months <u>--</u> Days <u>2</u>	IF UNDER 24 HRS. Hours <u>--</u> Min. <u>--</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-- -- -- --</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-- -- -- --</u>		11. BIRTHPLACE (State or foreign country) <u>Frostburg, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>-- --</u>
13. FATHER'S NAME <u>Harold Edward Schramm</u>				14. MOTHER'S MARDEN NAME <u>Alice Delberta Fazenbaker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>9 -- -- --</u> (If Yes, give war or dates of service) <u>-- -- -- --</u>			16. SOCIAL SECURITY NO. <u>-- -- -- --</u>		17. INFORMANT & ADDRESS <u>H.E. Schramm, box 353, Barton Md.</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
776X IMMEDIATE CAUSE (A) <u>Prematurity</u>						<u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO <u>Birth date was 2 months ahead of time</u>						<u>--</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>10:45 P.M.</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 4, 19 55</u> , to <u>June 6, 19 55</u> , that I last saw the deceased alive on <u>June 6, 19 55</u> , and that death occurred at <u>10:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John B. Davis M.D.</u>				ADDRESS (Street, city, town, state) <u>Frostburg, Maryland</u>		DATE SIGNED <u>6/6/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THROOF <u>6-7-55</u>		NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Moscow, Md.</u>	
24. REC'D BY REGISTRAR <u>6-7-55</u>		REGISTRAR'S SIGNATURE <u>Mrs. Nancy N. Rae</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E.S. Boal</u>		ADDRESS <u>111 Church St. Westernport, Md.</u>	

2065263322

FEDERAL BUREAU OF INVESTIGATION U. S. DEPARTMENT OF JUSTICE CERTIFICATE OF DEATH

WASHINGTON STATE DEPARTMENT OF HEALTH-BALTIMORE 10

See back

1. USUAL RESIDENCE (House or Apartment)

2. PLACE OF DEATH

3. DEATH CERTIFICATE NO. _____

4. DATE OF DEATH _____

5. TIME OF DEATH _____

6. CAUSE OF DEATH _____

7. MANNER OF DEATH _____

8. PLACE OF BURIAL _____

9. NAME OF FUNERAL HOME _____

10. NAME OF MINISTER _____

11. NAME OF CHURCH _____

12. NAME OF CEMETERY _____

13. NAME OF INTERVIEWER _____

14. NAME OF WITNESS _____

15. NAME OF SIGNER _____

16. NAME OF SIGNER _____

17. NAME OF SIGNER _____

18. NAME OF SIGNER _____

19. NAME OF SIGNER _____

20. NAME OF SIGNER _____

21. NAME OF SIGNER _____

22. NAME OF SIGNER _____

23. NAME OF SIGNER _____

24. NAME OF SIGNER _____

25. NAME OF SIGNER _____

26. NAME OF SIGNER _____

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32. NAME OF SIGNER _____

33. NAME OF SIGNER _____

34. NAME OF SIGNER _____

35. NAME OF SIGNER _____

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37. NAME OF SIGNER _____

38. NAME OF SIGNER _____

39. NAME OF SIGNER _____

40. NAME OF SIGNER _____

41. NAME OF SIGNER _____

42. NAME OF SIGNER _____

43. NAME OF SIGNER _____

44. NAME OF SIGNER _____

45. NAME OF SIGNER _____

46. NAME OF SIGNER _____

47. NAME OF SIGNER _____

48. NAME OF SIGNER _____

49. NAME OF SIGNER _____

50. NAME OF SIGNER _____

BUREAU V. 1

JUN 13 1955

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

DR W F WMS.

Without corporate limits

5184

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05205

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		STATE MARYLAND		COUNTY ALLEGANY			
CITY (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		LENGTH OF STAY (in this place) 2HRS. 5 MIN.		CITY (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL		STREET ADDRESS (If rural give location) 5 H JANE FRAZIER VILLAGE					
3. NAME OF DECEASED (Type or Print) KATHERINE (First) SEITZ (Last)				4. DATE OF DEATH (Month) JUNE (Day) 2 (Year) 1955			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) WIDOWED	8. DATE OF BIRTH JAN. 5 1875	9. AGE last birthday 80 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own house		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME JOHN SCHAFER				14. MOTHER'S MAIDEN NAME Sarah, WOLFE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS has Seitz 437 Independence St Cumbd Md			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
260X IMMEDIATE CAUSE (A) Coronary Thrombosis				Several			
ANTECEDENT CAUSE(S) DUE TO (B) Generalized Arteriosclerosis				Hours			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) Diabetes Mellitus							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4:26, 1955, to 6-2-55, that I last saw the deceased alive on 4:26, 1955, and that death occurred at 5:55 P.M. from the causes and on the date stated above.							
SIGNATURE W. F. Williams M.D.				DATE SIGNED 6-3-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 6 1955		NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		LOCATION (City, town, or county) (State) Cumberland Md.	
24. REC'D BY REGISTRAR June 6, 1955		REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE W. H. Kugel		ADDRESS Cumberland Md.	

RECEIVED

1. Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5185

CERTIFICATE OF DEATH

05206

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		STATE <u>MARYLAND</u>		COUNTY <u>ALLEGANY</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>02 CUMBERLAND</u>		LENGTH OF STAY (in this place) <u>3 Mon. 15 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>02 CUMBERLAND</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>62 SACRED HEART HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>527 GREEN ST.</u>			
3. NAME OF DECEASED (Type or Print) <u>ELLEN MARY L. SELL</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>6-11-55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 15, 1871</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Patrick J. Sullivan</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Griffin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs Phillip Christ, 527 Greene St. City</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443x IMMEDIATE CAUSE (A) <u>Myocardial Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Heart Disease</u>				<u>20 yr.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Cerebral Hemorrhage, recent</u>				<u>3 mo</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Generalized Arteriosclerosis Advanced</u>				<u>25 yr</u>			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>none</u>		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) <u>none</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>none</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>none</u>			
22. I hereby certify that I attended the deceased from <u>June 11, 1955</u> to <u>June 11, 1955</u> , that I last saw the deceased alive on <u>June 11, 1955</u> , and that death occurred at <u>8:25 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>G. P. Hallinan MD</u>				ADDRESS (Street, city, town, state) <u>146 Bedford St. Cumberland, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 14, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>S. S. Peter & Paul</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR <u>June 13, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George, Cumberland, Md.</u>			

02508

CERTIFICATE OF DEATH

For Use by

A. Name of Deceased

B. Date of Death

1. Name of Deceased	2. Date of Death
3. Sex	4. Age
5. Race	6. Marital Status
7. Occupation	8. Cause of Death
9. Place of Death	10. Signature of Physician
11. Signature of Registrar	12. Date of Registration

13. Name of Informant

14. Address of Informant

15. Date of Informant's Statement

16. Signature of Registrar

17. Date of Registration

18. Name of Informant

19. Address of Informant

20. Date of Informant's Statement

21. Signature of Registrar

22. Date of Registration

23. Name of Informant

24. Address of Informant

25. Date of Informant's Statement

26. Signature of Registrar

27. Date of Registration

28. Name of Informant

29. Address of Informant

30. Date of Informant's Statement

BUREAU V. S.

JUN 15 1951

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5210

05207

Dr Bess

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Moscow Mills</u>		<u>81 years</u>		TOWN <u>Moscow Mills</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED				4. DATE OF DEATH			
(First) <u>LLOYD</u> (Middle) <u>BRUCE</u> (Last) <u>SHAW</u>				(Month) <u>June</u> (Day) <u>3</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>September 19, 1873</u>	
9. AGE last birthday <u>81</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Farm etc</u>		11. BIRTHPLACE (State or foreign country) <u>Moscow Mills, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Andrew Bruce Shaw</u>				14. MOTHER'S MAIDEN NAME <u>Mary Martha</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-26-9350</u>		17. INFORMANT & ADDRESS <u>Andrew B. Shaw, Moscow Mills, Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>420.1</u>				CORONARY OCCLUSION			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio Sclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				<u>15 years</u>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 29, 1955</u> , to <u>June 3, 1955</u> , that I last saw the deceased alive on <u>June 3, 1955</u> , and that death occurred at <u>7:20</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Robert W. Bess</u> M.D.				DATE SIGNED <u>Piedmont, W.Va.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-6-55</u>		NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Moscow Mills, Md.</u>	
24. REC'D BY REGISTRAR <u>6-6-55</u>		REGISTRAR'S SIGNATURE <u>Mrs Jean C. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>G. S. Boal</u>		ADDRESS <u>Westernport, Md</u>	

CERTIFICATE OF DEATH

2010

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 18

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. PLACE OF BIRTH

12. DATE OF BIRTH

13. SEX

14. OCCUPATION

15. CAUSE OF DEATH

16. DATE OF DEATH

17. TIME OF DEATH

18. SIGNATURE OF PHYSICIAN

19. SIGNATURE OF REGISTRAR

20. PLACE OF BIRTH

21. DATE OF BIRTH

22. SEX

23. OCCUPATION

24. CAUSE OF DEATH

25. DATE OF DEATH

26. TIME OF DEATH

27. SIGNATURE OF PHYSICIAN

28. SIGNATURE OF REGISTRAR

29. PLACE OF BIRTH

30. DATE OF BIRTH

31. SEX

32. OCCUPATION

33. CAUSE OF DEATH

34. DATE OF DEATH

35. TIME OF DEATH

36. SIGNATURE OF PHYSICIAN

37. SIGNATURE OF REGISTRAR

RECEIVED

JUN 8 1955

BUREAU V. S.

1

INSTRUCTIONS

I

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5201

CERTIFICATE OF DEATH

05208

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>ALLEGANY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>22 Frostburg</u>		3 hours		TOWN <u>Frostburg, Md. 22</u>		1	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>61 Miners</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>BABY</u> (Middle) (Last) <u>SHOCKEY</u>				6 29 1955			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>6/28/55</u>	9. AGE last birthday <u>NO BORN</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
					<u>MARYLAND</u>		<u>USA</u>
13. FATHER'S NAME <u>SAL LOAR</u>				14. MOTHER'S MAIDEN NAME <u>(UNWED) Viola Virginia Shockey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>SAL LOAR, Midland, Md.</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				3 1/4 oz. 3 hrs			
776X IMMEDIATE CAUSE (A) <u>Prematurity</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>6/28</u> 19 <u>55</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/28</u> , 19 <u>55</u> , to <u>6/29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6/28</u> , 19 <u>55</u> , and that death occurred at <u>1245P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>John C. Devere</u> M.D.				ADDRESS (Street, city, town, state) <u>Frostburg, Md</u>		DATE SIGNED <u>6/29/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-29-55</u>		NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Frostburg Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Wm. Harry H. R.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Salmon Loar</u>		ADDRESS <u>Rt. 1 Frostburg Md.</u>	
DATE <u>6-29-55</u>							

2065331997

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. DATE OF BIRTH

11. SEX

12. AGE

13. OCCUPATION

14. CAUSE OF DEATH

15. DATE OF DEATH

16. TIME OF DEATH

17. PLACE OF BIRTH

18. DATE OF BIRTH

19. SEX

20. AGE

21. OCCUPATION

22. CAUSE OF DEATH

23. DATE OF DEATH

24. TIME OF DEATH

25. PLACE OF BIRTH

26. DATE OF BIRTH

27. SEX

28. AGE

29. OCCUPATION

30. CAUSE OF DEATH

31. DATE OF DEATH

32. TIME OF DEATH

33. PLACE OF BIRTH

34. DATE OF BIRTH

35. SEX

36. AGE

37. OCCUPATION

38. CAUSE OF DEATH

39. DATE OF DEATH

40. TIME OF DEATH

41. PLACE OF BIRTH

42. DATE OF BIRTH

43. SEX

44. AGE

45. OCCUPATION

46. CAUSE OF DEATH

47. DATE OF DEATH

48. TIME OF DEATH

49. PLACE OF BIRTH

50. DATE OF BIRTH

51. SEX

52. AGE

53. OCCUPATION

54. CAUSE OF DEATH

55. DATE OF DEATH

56. TIME OF DEATH

57. PLACE OF BIRTH

58. DATE OF BIRTH

59. SEX

60. AGE

BUREAU VI

JUL 5 1955

RECEIVED

RECORDED & INDEXED
JUL 12 1955

2001 JUSTICE

5186

CERTIFICATE OF DEATH

05209

DR. HALLINAN

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		STATE MARYLAND		COUNTY ALLEGANY			
CITY (If outside corporate limits, write RURAL and give nearest town) 02 TOWN CUMBERLAND		LENGTH OF STAY (In this place) 8 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) near CUMBERLAND, rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 MEMORIAL HOSPITAL		STREET ADDRESS RT. #3, BEDFORD ROAD					
3. NAME OF DECEASED (First) (Middle) (Last) FREEMAN W. SIMONS				4. DATE OF DEATH (Month) (Day) (Year) JUNE 23 19 55			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 20 SEPT. 3, 1888	9. AGE last birthday 66 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY Cemetery empl oyee		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY SIMONS				14. MOTHER'S MAIDEN NAME MARY RICE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 212-24-0453		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) Massive cerebral Hemorrhage				8 P.A.			
ANTECEDENT CAUSE(S) DUE TO (B) Hypertensive Heart Disease				15 YR.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Generalized Arteriosclerosis				20 YR.			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Obesity - MARKED							
19. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION none		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) none		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) none		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 15, 1955, to June 15, 1955, that I last saw the deceased alive on June 15, 1955, and that death occurred at 12:14 P.M. from the causes and on the date stated above.							
SIGNATURE J. Hallinan M.D.				ADDRESS (Street, city, town, state) 116 Bedford St. Cumberland, Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 25, 1955		NAME OF CEMETERY OR CREMATORY Zion Memorial Cem.		LOCATION (City, town, or county) (State) Cumberland, Md.	
24. REC'D BY REGISTRAR June 25, 1955		REGISTRAR'S SIGNATURE Walter R. Brant, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

7188 CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE, MD

FILE NO. 116

1. NAME OF DECEASED: [REDACTED]

2. SEX: [REDACTED] 3. AGE: [REDACTED]

4. DATE OF BIRTH: [REDACTED] 5. PLACE OF BIRTH: [REDACTED]

6. DATE OF DEATH: [REDACTED] 7. PLACE OF DEATH: [REDACTED]

8. CAUSE OF DEATH: [REDACTED]

9. MANNER OF DEATH: [REDACTED]

10. SIGNATURE OF DECEASED: [REDACTED]

11. SIGNATURE OF WITNESS: [REDACTED]

12. SIGNATURE OF PHYSICIAN: [REDACTED]

13. SIGNATURE OF CLERK: [REDACTED]

14. SIGNATURE OF JUDGE: [REDACTED]

15. SIGNATURE OF NOTARY: [REDACTED]

16. SIGNATURE OF [REDACTED]: [REDACTED]

17. SIGNATURE OF [REDACTED]: [REDACTED]

18. SIGNATURE OF [REDACTED]: [REDACTED]

19. SIGNATURE OF [REDACTED]: [REDACTED]

20. SIGNATURE OF [REDACTED]: [REDACTED]

21. SIGNATURE OF [REDACTED]: [REDACTED]

22. SIGNATURE OF [REDACTED]: [REDACTED]

23. SIGNATURE OF [REDACTED]: [REDACTED]

24. SIGNATURE OF [REDACTED]: [REDACTED]

25. SIGNATURE OF [REDACTED]: [REDACTED]

26. SIGNATURE OF [REDACTED]: [REDACTED]

27. SIGNATURE OF [REDACTED]: [REDACTED]

28. SIGNATURE OF [REDACTED]: [REDACTED]

29. SIGNATURE OF [REDACTED]: [REDACTED]

30. SIGNATURE OF [REDACTED]: [REDACTED]

31. SIGNATURE OF [REDACTED]: [REDACTED]

32. SIGNATURE OF [REDACTED]: [REDACTED]

BUREAU V. 3

JUN 28 1955

RECEIVED

Charles J. [REDACTED]

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5211

CERTIFICATE OF DEATH

05210

Reg. Dist. No. 10

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>ALLEGANY</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>MT. SAVAGE</u>		<u>45 years</u>		TOWN <u>MT. SAVAGE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>FLORENCE</u> (First) <u>SNELSON</u> (Middle) (Last)				4. DATE OF DEATH <u>JUNE 28</u> 19 <u>55</u> (Month) (Day) (Year)			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>April 18, 1888</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Yorkshire, England</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE ROLFE</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH ROLFE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Thomas Snelson, Mt. SAVAGE, Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
260X IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>						<u>15 mins</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Arteriosclerotic Hypertensive Heart Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Dilated Pericarditis, Nephrosclerosis</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/1</u> , 19 <u>54</u> , to <u>6/28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6/28</u> , 19 <u>55</u> , and that death occurred at <u>6:35 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John C. Deven</u>				ADDRESS (Street, city, town, state) <u>744 Frostburg, Md.</u>		DATE SIGNED <u>6/30/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>July 2, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. George Episcopal</u>		LOCATION (City, town, or county) <u>Mt. SAVAGE, Md.</u>	
24. REC'D BY REGISTRAR <u>Veronica McDermitt</u>		REGISTRAR'S SIGNATURE <u>Veronica McDermitt</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HARVEY H. Zeigler</u>		ADDRESS <u>Hyndman</u>	
DATE <u>6/30/55</u>							

CERTIFICATE OF DEATH

FILE

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. STATE OF DEATH

10. SIGNATURE

12. Manner of Death
 Coronary Atherosclerotic Heart Disease
 Diabetes Mellitus, Type 2
 12.12.1955

BUREAU V. 5

JUL 5 1955

RECEIVED
 6/30/55

John C. Green
 6/30/55

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5187

CERTIFICATE OF DEATH

05211

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>02</u> TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>30 Yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>02</u> TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 N. Mechanic St.</u>				STREET ADDRESS (If rural give location) <u>50 N. Mechanic St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Jacob</u>		(Middle) <u>M</u>		(Last) <u>Spiker</u>		(Date) <u>June 16</u> 19 <u>55</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>May 12, 1889</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dept Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kelly Springfield</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas J Spiker</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca McKimney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>War 1</u>		16. SOCIAL SECURITY NO. <u>214-07-1015</u>		17. INFORMANT & ADDRESS <u>Howard M Spiker Cumberland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
153X IMMEDIATE CAUSE (A) <u>Carcinomatosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr. 3 wks and 5 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of sigmoid</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>None</u>						<u>1 yr.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>5-21-54</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of sigmoid with metastases to glands and liver</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) and (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u> </u> <u> </u> <u> </u> <u> </u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 14, 1954</u> , to <u>June 16, 1955</u> , that I last saw the deceased alive on <u>June 13, 1955</u> , and that death occurred at <u>3:20 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Rebecca McKimney</u>				ADDRESS (Street, city, town, state) <u>105 S. Centre St.</u>		DATE SIGNED <u>6-17-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>6/16/55</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland Maryland</u>	
24. REC'D BY REGISTRAR <u>June 18, 1955</u>		REGISTRAR'S SIGNATURE <u>White R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Louis Stein, Inc. Cumberland, Md.</u>			

CERTIFICATE OF DEATH

REG. CASE NO.

1. LOCAL RESIDENCE WHEN DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BURIAL

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF CLERK

15. SIGNATURE OF JURY

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83. SIGNATURE OF JURY

84. SIGNATURE OF JURY

RECEIVED

BUREAU V. 2

JUN 21 1955

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5188 CERTIFICATE OF DEATH

05212

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		LENGTH OF STAY (in this place) <u>21 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u>		TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sylvan Retreat</u>				STREET ADDRESS (If rural give location) <u>Railroad Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Margaret</u> (First) <u>Thomas</u> (Middle) <u></u> (Last)				4. DATE OF DEATH (Month) <u>June</u> (Day) <u>13</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>April, 28, 1886</u>		9. AGE last birthday <u>69</u> yrs.	10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Lonaconing, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Norman Miller</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. John Duckworth, (Daughter)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION (<u>Lonaconing, Md.</u>)		INTERVAL BETWEEN ONSET AND DEATH	
<u>422.1</u> IMMEDIATE CAUSE (A) <u>Pulmonary Hypostasis</u>						<u>48 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic myocarditis</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>General Arteriosclerosis</u>						<u>?</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Dementia Praecox -</u>						<u>21 yrs</u>	
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 2, 1955</u> , to <u>June 12, 1955</u> , that I last saw the deceased alive on <u>June 12, 1955</u> , and that death occurred at <u>12:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James B. DeLean</u> M.D.				ADDRESS (Street, city, town, state) <u>49 Grecco St.</u>		DATE SIGNED <u>6-13-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June, 15, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Lonaconing, MD.</u>	
24. REC'D BY REGISTRAR <u>June 14, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn, Lonaconing, MD.</u>		ADDRESS	

CERTIFICATE OF DEATH

State of Mass.

County of Middlesex

City of Boston

Ward 1

Street 1234

Age 45

Sex Male

Color White

Married

Occupation

BUREAU V. S.

JUN 15 1955

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
RECEIVED
JUN 15 1955
MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
RECEIVED

1. With corporate limits

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5189

CERTIFICATE OF DEATH

05213

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE FLORIDA		COUNTY DADE	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CUMBERLAND		LENGTH OF STAY (In this place) 6 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN MIAMI			
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS (If rural give location) 201 SOUTH WEST 52ND ST.,			
3. NAME OF DECEASED (Type or Print) (First) CLARENCE (Middle) L. (Last) TOLSON				4. DATE OF DEATH (Month) JUNE (Day) 6 (Year) 19 55			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH XXXXXX 1/18/98	9. AGE last birthday 57 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MARINE ENGINEER			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME HOWARD L. TOLSON				14. MOTHER'S MAIDEN NAME MARGARET EYRING			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) Yes UNK World War I			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) Coronary Thrombosis						Short	
ANTECEDENT CAUSE(S) DUE TO Coronary Artery Disease						time	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Operation sigmoidal hernia						6-4-55	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5:31, 19 55, to 6-6-55, that I last saw the deceased alive on 6-5-55, end that death occurred at 2:10 P.M. from the causes end on the date stated above.							
SIGNATURE M. J. Williams M.D.				ADDRESS (Street, city, town, state) Cumberland		DATE SIGNED 6-6-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 9- 1955		NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		LOCATION (City, town, or county) Cumberland Maryland	
24. REC'D BY REGISTRAR June 9, 1955		REGISTRAR'S SIGNATURE Winter R. Frank, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.,		ADDRESS Cumberland, Md.	

5182 CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. DATE OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF MAYOR

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF TOWNSHIP CLERK

18. SIGNATURE OF COUNTY CLERK

19. SIGNATURE OF STATE CLERK

20. SIGNATURE OF U.S. DEPARTMENT OF HEALTH

21. NAME OF DECEASED

22. SEX

23. AGE

24. DATE OF BIRTH

25. PLACE OF BIRTH

26. DATE OF DEATH

27. PLACE OF DEATH

28. CAUSE OF DEATH

29. MANNER OF DEATH

30. SIGNATURE OF DECEASED

31. SIGNATURE OF WITNESSES

32. SIGNATURE OF PHYSICIAN

33. SIGNATURE OF CLERK

34. SIGNATURE OF JUDGE

35. SIGNATURE OF MAYOR

36. SIGNATURE OF SHERIFF

37. SIGNATURE OF TOWNSHIP CLERK

38. SIGNATURE OF COUNTY CLERK

39. SIGNATURE OF STATE CLERK

40. SIGNATURE OF U.S. DEPARTMENT OF HEALTH

41. NAME OF DECEASED

42. SEX

43. AGE

44. DATE OF BIRTH

45. PLACE OF BIRTH

46. DATE OF DEATH

47. PLACE OF DEATH

48. CAUSE OF DEATH

49. MANNER OF DEATH

50. SIGNATURE OF DECEASED

51. SIGNATURE OF WITNESSES

52. SIGNATURE OF PHYSICIAN

53. SIGNATURE OF CLERK

54. SIGNATURE OF JUDGE

55. SIGNATURE OF MAYOR

56. SIGNATURE OF SHERIFF

57. SIGNATURE OF TOWNSHIP CLERK

58. SIGNATURE OF COUNTY CLERK

59. SIGNATURE OF STATE CLERK

60. SIGNATURE OF U.S. DEPARTMENT OF HEALTH

61. NAME OF DECEASED

62. SEX

63. AGE

64. DATE OF BIRTH

65. PLACE OF BIRTH

66. DATE OF DEATH

67. PLACE OF DEATH

68. CAUSE OF DEATH

69. MANNER OF DEATH

70. SIGNATURE OF DECEASED

71. SIGNATURE OF WITNESSES

72. SIGNATURE OF PHYSICIAN

73. SIGNATURE OF CLERK

74. SIGNATURE OF JUDGE

75. SIGNATURE OF MAYOR

76. SIGNATURE OF SHERIFF

77. SIGNATURE OF TOWNSHIP CLERK

78. SIGNATURE OF COUNTY CLERK

79. SIGNATURE OF STATE CLERK

80. SIGNATURE OF U.S. DEPARTMENT OF HEALTH

81. NAME OF DECEASED

82. SEX

83. AGE

84. DATE OF BIRTH

85. PLACE OF BIRTH

86. DATE OF DEATH

87. PLACE OF DEATH

88. CAUSE OF DEATH

89. MANNER OF DEATH

90. SIGNATURE OF DECEASED

91. SIGNATURE OF WITNESSES

92. SIGNATURE OF PHYSICIAN

93. SIGNATURE OF CLERK

94. SIGNATURE OF JUDGE

95. SIGNATURE OF MAYOR

96. SIGNATURE OF SHERIFF

97. SIGNATURE OF TOWNSHIP CLERK

98. SIGNATURE OF COUNTY CLERK

99. SIGNATURE OF STATE CLERK

100. SIGNATURE OF U.S. DEPARTMENT OF HEALTH

BUREAU V. S.

JUN 18 1913

RECEIVED

RECEIVED
JUN 18 1913
U.S. DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:

COUNTY

Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)

TOWN

Cumberland

LENGTH OF STAY
(in this place)

2 days

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Maryland

COUNTY Allegany

CITY (If outside corporate limits write RURAL and give nearest town)

OR

TOWN Cumberland

STREET
ADDRESS

(If rural, give location)

100 Virginia Ave.

3. NAME OF
DECEASED:
(Type or Print)

(First)

(Middle)

(Last)

Margaret

A.

Twigg

4. DATE
OF
DEATH

(Month)

(Day)

(Year)

June

8

19

55

5. SEX:

6. COLOR OR
RACE:7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.

female

white

widow

Sept 29-1874

80

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
if retired)

Housewife

10b. KIND OF BUSINESS OR
INDUSTRY:

Own Home

11. BIRTHPLACE (State or foreign country):

Luray, Va.

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME:

John F. Weaver

14. MOTHER'S MAIDEN NAME:

Laura F. Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

no

16. SOCIAL SECURITY No.:

none

17. INFORMANT & ADDRESS:

(daughter) Mrs. Viola Corbin, Cumberland, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

434.3

Immediate cause

(a) Myocardial failure

DUE TO

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating underlying cause last

(b) Cardiac decompensation

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

gradual

2 yrs.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.21b. PLACE (Home, farm, factory,
OF street, office bldg., etc.,
INJURY home

21c. (City or town)

(County)

(State)

Cumberland Allegany

Md.

21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY June 6-1955 A.M.21e. INJURY OCCURRED
While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR?

Sitting alone on side
of bed, fell to floor & hit head on bed22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and
find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

H.V. Deming M.D. H.V. Deming M.D.

M. D.

CHIEF MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER
ASSISTANT MEDICAL EXAM.

DATE SIGNED

June 9-1955

23. BURIAL, CREMATION,
REMOVAL, (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 10, 1955 Walter L. Ranz, M.D.

James Scarfelli, Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

JUN 13 1955

RECEIVED

VS. A15A-6

1

5191

05215

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:

COUNTY Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

LENGTH OF STAY (in this place)

TOWN Cumberland

2 weeks

HOSPITAL OR INSTITUTION OR STREET ADDRESS

245 N. Mechanic St.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md.

COUNTY Allegany

CITY (If outside corporate limits write RURAL and give nearest town)

TOWN Cumberland

STREET ADDRESS

(If rural, give location)

245 N. Mechanic St.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print) Charles

William

Viney

4. DATE OF DEATH

(Month)

(Day)

(Year)

June 25 19 55

5. SEX:

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.

male

white

married

Jan. 20-1901

54

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, if retired)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

Calendar operator - Kelley-Springfield

Covington, Va.

U.S.A.

13. FATHER'S NAME:

Walter F. Viney

14. MOTHER'S MAIDEN NAME:

Rose Riley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

214-07-0343

17. INFORMANT & ADDRESS:

(sister) Mildred Condey, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

420, 1

Immediate cause

(a)

Coronary occlusion

DUE TO

Antecedent cause(s)

(b)

Coronary sclerosis also had

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO

(c)

Cardiac hypertrophy

?

?

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

H.V. Deming M.D.

H.V. Deming M.D.

M. D.

CHIEF MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER
ASSISTANT MEDICAL EXAM.

DATE SIGNED

June 25-1955

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 27, 1955

Robert R. Frantz, M.D.

John J. Saffer

"

BUREAU V. S.

JUN 28 1955

RECEIVED

5192

CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

ENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>25 Yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>151 Bedford St.</u>				STREET ADDRESS (If rural give location) <u>151 Bedford St.</u>			
3. NAME OF DECEASED (Type or Print) <u>Hilda</u> (First) <u>S</u> (Middle) <u>Wiebel</u> (Last)				4. DATE OF DEATH <u>June</u> <u>8</u> <u>1955</u> (Month) (Day) (Year)			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3/25/1891</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore Smouse</u>				14. MOTHER'S MAIDEN NAME <u>Ma ry Topper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Frederick Wiebel Cumberland, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>144X</u> IMMEDIATE CAUSE (A) <u>metastatic Carcinomatosis</u>							
ANTECEDENT CAUSE(S) DUE TO <u>to brain, clavicle</u>						<u>1 year</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Carcinoma of Soft Palate</u>						<u>3 year</u>	
(C) <u>Osteoporosis</u>						<u>2.</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>June 1952</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Soft Palate</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office-bldg, etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>52</u> , to <u>June 8</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>June 6</u> , 19 <u>55</u> , and that death occurred at <u>9 a</u> .M, from the causes and on the date stated above.							
SIGNATURE <u>David G. Weissman MD</u>				ADDRESS (Street, city, town, state) <u>M.D. Cumberland Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>6/10/55</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	
24. REC'D BY REGISTRAR <u>June 9, 1955</u>				REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc.</u>	
						LOCATION (City, town, or county) (State) <u>Cumberland Maryland</u>	

CERTIFICATE OF DEATH

5183

1. FULL NAME OF DECEASED

JOHN J. ROSS

2. SEX

Male

3. AGE

62

4. DATE OF DEATH

April 1, 1945

5. TIME OF DEATH

10:30 AM

6. PLACE OF DEATH

Home

7. CAUSE OF DEATH

Myocardial Infarction

8. DISEASE OR INJURY

Coronary Artery Disease

9. SIGNATURE OF PHYSICIAN

J. H. ROSS

10. SIGNATURE OF REGISTRAR

J. H. ROSS

11. SIGNATURE OF WITNESSES

J. H. ROSS

12. SIGNATURE OF DECEASED

J. H. ROSS

13. SIGNATURE OF DECEASED

J. H. ROSS

14. SIGNATURE OF DECEASED

J. H. ROSS

15. SIGNATURE OF DECEASED

J. H. ROSS

16. SIGNATURE OF DECEASED

J. H. ROSS

17. SIGNATURE OF DECEASED

J. H. ROSS

18. SIGNATURE OF DECEASED

J. H. ROSS

19. SIGNATURE OF DECEASED

J. H. ROSS

20. SIGNATURE OF DECEASED

J. H. ROSS

21. SIGNATURE OF DECEASED

J. H. ROSS

22. SIGNATURE OF DECEASED

J. H. ROSS

1. FULL NAME OF DECEASED

JOHN J. ROSS

2. SEX

Male

3. AGE

62

4. DATE OF DEATH

April 1, 1945

5. TIME OF DEATH

10:30 AM

6. PLACE OF DEATH

Home

7. CAUSE OF DEATH

Myocardial Infarction

8. DISEASE OR INJURY

Coronary Artery Disease

9. SIGNATURE OF PHYSICIAN

J. H. ROSS

10. SIGNATURE OF REGISTRAR

J. H. ROSS

11. SIGNATURE OF WITNESSES

J. H. ROSS

12. SIGNATURE OF DECEASED

J. H. ROSS

13. SIGNATURE OF DECEASED

J. H. ROSS

14. SIGNATURE OF DECEASED

J. H. ROSS

15. SIGNATURE OF DECEASED

J. H. ROSS

16. SIGNATURE OF DECEASED

J. H. ROSS

17. SIGNATURE OF DECEASED

J. H. ROSS

18. SIGNATURE OF DECEASED

J. H. ROSS

19. SIGNATURE OF DECEASED

J. H. ROSS

20. SIGNATURE OF DECEASED

J. H. ROSS

21. SIGNATURE OF DECEASED

J. H. ROSS

1. FULL NAME OF DECEASED

JOHN J. ROSS

2. SEX

Male

3. AGE

62

4. DATE OF DEATH

April 1, 1945

5. TIME OF DEATH

10:30 AM

6. PLACE OF DEATH

Home

7. CAUSE OF DEATH

Myocardial Infarction

8. DISEASE OR INJURY

Coronary Artery Disease

9. SIGNATURE OF PHYSICIAN

J. H. ROSS

10. SIGNATURE OF REGISTRAR

J. H. ROSS

11. SIGNATURE OF WITNESSES

J. H. ROSS

12. SIGNATURE OF DECEASED

J. H. ROSS

13. SIGNATURE OF DECEASED

J. H. ROSS

14. SIGNATURE OF DECEASED

J. H. ROSS

15. SIGNATURE OF DECEASED

J. H. ROSS

16. SIGNATURE OF DECEASED

J. H. ROSS

17. SIGNATURE OF DECEASED

J. H. ROSS

18. SIGNATURE OF DECEASED

J. H. ROSS

19. SIGNATURE OF DECEASED

J. H. ROSS

EMERGENCY

BUREAU V. S.

JUN 10 1945

RECEIVED

5222

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. **05217**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
TOWN <u>Frostburg</u>		<u>41 yrs.</u>		TOWN <u>Frostburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D.#1 (National)</u>				STREET ADDRESS (If rural, give location) <u>R.F.D.#1 (National)</u>			
3. NAME OF DECEASED: (Type or Print) <u>Peter Lawrence Joseph Ziler</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 11 19 55</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>Oct. 6-1872</u>	
9. AGE last birthday: <u>82</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, except if retired) <u>Retired Car Repairman</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>C&P.R.Ry.</u>		11. BIRTHPLACE (State or foreign country): <u>W.Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>Wilson Ziler</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Cosgrove</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>(son) Joseph F. Ziler, R.F.D.#1 Frostburg Md.</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<u>422.1</u> Immediate cause (a) <u>Myocardial failure</u> DUE TO				<u>Gradual</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) <u>Chronic myocarditis also had</u> DUE TO				<u>?</u>	
(c) <u>Arteriosclerosis</u>				<u>?</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Fracture, surgical neck, left femur.</u>				<u>4 weeks.</u>	
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY) <u>home</u>		21c. (City or town) (County) (State) <u>R.F.D.#1 (National) Frostburg, Allegany, Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>May 15/55 A.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>went to sit on side of bed, missed bed, fell to the floor.</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.					
SIGNATURE <u>H.V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM. <u>June 11-1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>6-14-55</u>		NAME OF CEMETERY OR CREMATORY <u>Methodist Church Cemetery</u>	
LOCATION (City, town, or county) (State) <u>Mt. Savage, Md.</u>					
24. FUNERAL DIRECTOR <u>Jacob Hafer, 23 E. Main, Frostburg, Md.</u>		ADDRESS			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED JUN 15 1935

BUREAU V. S.

JUN 15 1935

RECEIVED